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THE MEDICAL JOURNAL OF AUSTRALIA.

VOL. I.—5TH YEAR. SYDNEY: SATURDAY, JANUARY 26, 1918. No. 4.

NOTES ON MILITARY ORTHOPÆDICS.[1]

By **Victor Hurley, M.D., Ch.M. (Melb.),**
Lieutenant-Colonel; Assistant Director Medical Services, Australian Imperial Force;
and
Hugh R. G. Poate, M.B., Ch.M. (Syd.), F.R.C.S. (Eng.),
Lieutenant-Colonel, No. 3 Australian General Hospital.

The following notes, which we hope will prove of general interest, are based directly on experience gained during the past few months, when we have been able, by permission of Surgeon-General Sir Neville Howse, V.C., K.C.B., D.M.S., A.I.F., to visit regularly the military orthopædic centres at Roehampton, No. 2 Australian Auxiliary Hospital, Southall, and the Military Orthopædic Hospital, Shepherd's Bush, London.

At the first two hospitals Lieutenant-Colonel T. H. Openshaw, C.B., C.M.G., R.A.M.C., Consulting Surgeon, Southern Command, has been our guide and instructor. Whilst at the Shepherd's Bush Hospital, Colonel Robert Jones, C.B., A.M.S., Director of Military Orthopædics, and the Consulting Staff of the Hospital, have been most courteous in showing and explaining to us the work carried on under their direction.

Although all that we saw may be included under the heading of orthopædics, it is convenient for the purposes of this paper to divide it into the two classes that were dealt with (1) at Roehampton and the No. 2 Australian Auxiliary Hospital, where amputation cases and artificial limbs were chiefly concerned, and (2) at Shepherd's Bush, where various deformities, the result of bone, muscle or nerve injuries, were centred for relief.

Part I.

Stumps and Artificial Limbs.

It is not our intention to enter into a discussion on the various factors to be taken into consideration before determining on an amputation. We wish to point out that our remarks in the following notes are based on the very great experience of Lieutenant-Colonal Openshaw, as well as the relatively limited experience of our two selves. Our remarks are directed more particularly to the end results of amputations and the adaptability of the various stumps met with for the fitting and effective using of an artificial limb.

We may, however, be allowed to enter a protest against the "guillotine" amputation, so frequently carried out through the healthy tissues of a limb some distance above the original lesion. Performed in this fashion, the operation is a most pernicious one, and can by no means be regarded as a life-saving measure (the great excuse for its performance), as shock is increased by the further damage to healthy tissues. A re-amputation is generally a necessity later on, and a further length of limb must be sacrificed.

When a limb has been badly smashed, the ideal operation is a section of the limb made through the seat of fracture, leaving the bone protruding if the soft parts need extensive removal, but whenever possible an attempt should be made to leave flaps of some sort, even if they have to be sewn back to allow of a full exposure of the raw area for drainage, as it makes a very big difference in the healing.

Stumps in general should be carefully examined as regards the following points before being passed for the fitting of an artificial limb:—

1. *Bulbous and Tender Nerve Ends.*—These are frequently met with, especially in the larger nerves, from the size of the anterior tibial up to the sciatic. Often they are involved in the cicatricial tissue of the scar, by the contraction of which they may be displaced from their normal position. At times bulbous nerve ends can be felt which are not painful, but if there is any tenderness the nerve must be excised. Perhaps the most difficult situation to deal with is the brachial plexus in high amputations of the arm.

For some time one of us has adopted the practice of firmly ligaturing all nerves with catgut, and this seems greatly to minimize the development of end bulbs, due probably to the fact that the neurilemma is drawn over the ends of the injured fibrils, and so diminishes their tendency to wander outside their limiting membrane.

2. *The Scar.*—As a rule, as long as the scar is freely moveable over the end of the bone, and will stand an equal pull over the circumference of the limb without becoming ischæmic, it will pass, even though it be wide or puckered. The mobility depends primarily upon the operator having been able to draw a good fatty pad over the end of the bone. It is not worth while suturing muscle, as it invariably atrophies, and only the fatty pad is left to cover the bone.

If the scar is stretched and adherent it must be excised, the edges undermined and brought over without tension, even though 0.5 to 1.25 cm. of bone may have to be removed. In some cases where there is a puckered scar with a delicate surrounding skin, as is so often seen in thigh amputations, an eczematous condition may develope, which is difficult to cure unless the whole scar be excised and the skin edges so sutured as to prevent any puckering.

Frequently a broad, thin scar is seen, which, even without tension, and certainly with it, will blister or break down, and no treatment, however prolonged, is of any avail, and excision must be resorted to.

Sinuses may exist for many months after an amputation or re-amputation, and at times their causes are difficult to detect. X-rays may give a clue, but any obstinate cases should either be excised or the track laid well open, curetted and allowed to granulate up from the bottom.

3. *Œdema of the Stump* is frequently seen persisting for many weeks after an otherwise perfectly

[1] This article was forwarded to us from France early in 1917, but failed to reach its destination. Dr. Poate, on his return to Australia, kindly supplied us with a duplicate of the manuscript.

healed amputation, and must be dispersed before a limb can be fitted. Very firm bandaging, with some massage and exercise of the stump, usually dispels it in seven to fourteen days.

4. *Range of Movement* of the stump must always be carefully watched, and attention must be directed to maintaining the full range of joint movement during the healing of the wound. If any contracture has developed, appropriate measures must be adopted for its removal before a limb will be of any use. This applies particularly to thigh stumps, as a flexion of ten to fifteen degrees makes it almost impossible for a limb to be worn with any degree of comfort or satisfaction.

5. *Bony Spines* are often seen resulting from an outgrowth of callus along tendinous insertions or intermuscular septa. They are met with particularly about the lower end of the humerus, and are especially common about the femur, along the *linea aspera*. If they cause any tenderness on pressure, they must be removed.

Attention may here be drawn to the frequency with which tender spots, blisters or ulcers develope over the crest of the tibia after the fitting of limbs when care has not been taken to round off this bony prominence thoroughly; but, as a rule, these troubles can be relieved by moulding of the leg bucket over the affected area, so as to relieve all pressure.

Having considered the general points to be observed about stumps, we may pass to a more special consideration of upper and lower limbs stumps, and give some useful points concerning levels of amputations.

Upper Limb Stumps.

(*a*) *Below the Elbow Joint.*—The shortest forearm stump to which an artificial limb can be applied is one measuring five centimetres from the tip of the olecranon. It is useless trying to save anything shorter than this, as a limb can be much more conveniently fitted to the stump of an amputation done through the upper arm, just above the condyles of the humerus. Experience has shown with forearm stumps of five to ten centimetres in length that excision of the origins of the flexor and extensor groups of muscles from the lower end of the humerus is of great advantage, and in the very short stumps is a necessity. This procedure increases the weight-bearing area of the stump, by allowing the bucket to be fitted closely to the bony support. The stump does not tend to slip out of the bucket, as it so often does if these muscles are left, for on flexion of the elbow they contract synergically with the upper arm flexors and lift the stump out of the bucket.

There is no particular advantage to be gained from a long forearm stump; in fact, the best amputation is one of not more than 20 cm. in length. In cases where an amputation has been done through the wrist, Lieutenant-Colonel Openshaw recommends a sub-periosteal excision of two and a half centimetres of the radius and ulna, about three and three-quarters centimetres from their distal extremities. If the periosteum be sewn over the ends of the bones, a false wrist-joint may be obtained, to which a very useful hand can be fitted, and so arranged that flexion and extension of the end of the stump produces opening or closing of the fingers on the thumb in the artificial limb.

(*b*) *Above the Elbow Joint.*—Amputation through the elbow joint is the most unsatisfactory stump to fit with a useful limb. The end of the stump is too wide to slip into the ordinary upper-arm bucket, and it is difficult to arrange a workable elbow joint. It is much better to amputate just above the condyles of the humerus, as this gives the most desirable and easily fitted stump for the upper limb.

Just as is the case with short forearm stumps, so with short upper-arm stumps, the weight-bearing area can be considerably increased by excision of the humeral attachments and some of the musculature of the *pectoralis major* and *latissimus dorsi* muscles. If this does not give a stump of sufficient length to carry a bucket efficiently, then these cases should be fitted much in the same way as is done with a dis-articulation at the shoulder joint. At first it was found difficult to fit these cases with a satisfactory limb, but if a moulded leather shoulder cap be made, it can be incorporated with a limb, provided that care be taken to leave sufficient space in the axilla for the clothes to fit comfortably. If there is a short upper-arm stump, the limb can be connected by a curved steel piece to the shoulder-cap over the point of the shoulder, with a joint allowing movements of flexion and extension. It should be situated over the greater tuberosity, so as to lie in the same plane as the centre of the shoulder joint.

Taken as a whole, amputation stumps of the superior extremity are much more satisfactory for the operating surgeon to deal with than those of the lower extremity; but the reverse is the case for the orthopædist, as artificial arms present much more difficult mechanical problems, as far as utility and efficiency are concerned, than do artificial legs.

As regards hand movements, all that can be done with the usual type of limb is to provide a moveable thumb, which is worked by means of a Bowden wire from a loop over the opposite shoulder, and opposes the semi-flexed index and middle finger. Lieutenant-Colonel Openshaw is very insistent on having the little and ring fingers flexed to such a degree as to form a hook, of which good use can be made, and it is astonishing what a great weight can be supported in this way.

In most cases the hand can be unscrewed at the wrist, and a number of appliances can be attached in its place, the most useful of which is a split hook, the opening of which is regulated by the same apparatus as that for moving the thumb.

At the best, an artificial elbow joint is an unsatisfactory mechanism; in some limbs the Bowden wire apparatus is used for flexion of the forearm to any required degree, and a ratchet is provided for fixing it at the desired angle. In the more elaborate arms, a number of movements are possible; but these limbs are rather costly, and require more attention and care than the average working man cares to devote to them. They are of much more use to the educated man who leads a quiet existence and requires the limb more for its cosmetic effect than for any useful purpose.

Lower Limb Stumps.

(*a*) *Below the Knee Joint.*—The shortest stump just below the knee to which it is possible to fit a satisfactory limb is an amputation at the level of the lowest limit of the tubercle of the tibia. With any

stump shorter than this it is better to amputate through the knee-joint. The best stump in the leg is one corresponding to the lowest level of the belly of the gastrocnemius muscle and corresponds to much the same level as the old "site of election."

There is no advantage at all to be obtained in performing any amputation below this level, unless one can save enough tissue to do a "Syme," which is the only stump in the region of the foot to which a limb can be attached satisfactorily.

In any leg amputation, care should be taken to bevel and round off the crest of the tibia, and to divide the fibula at least one and a quarter centimetres higher than the tibia, as it has been noticed that the fibula, released from its spring contact with the lower end of the tibia, apparently elongates and projects below the cut end of the tibia in a stump, and may cause some inconvenience. In short leg stumps it is sometimes of value, in order to fit a limb satisfactorily, to excise some of the musculature of the gastrocnemius, in order to prevent the stump from pulling out of the bucket, which in such cases must embrace the stump very firmly.

A good leg stump is, from the cosmetic point of view, the best we have for fitting with an artificial limb, as, after a few weeks' careful practice, the patient can walk so naturally that it is difficult to detect that he has anything abnormal about him at all.

(*b*) *Through the Knee Joint.*—Unlike the corresponding level in the upper limb, an amputation through the knee joint is a very satisfactory stump to fit. The best amputation is that of Stephen Smith, but with removal of the patella. An artificial knee joint is a very satisfactory mechanical arrangement, provided the hinge is centred properly at the level of the transverse axis of the joint, and efficient support is given by a well-fitting bucket, to be laced up the centre of the thigh in front.

(*c*) *Above the Knee Joint.*—The cardinal rule is to leave as long a stump in the thigh as one can, for the higher the level of amputation the less satisfactory (to the patient) is the fitting of the limb.

Experience has now proved that with all amputations through or above the centre of the thigh, it is necessary to order a pelvic band for attachment to the upper part of the thigh bucket. In such cases one must watch very carefully that the maker has adjusted the band correctly and placed the joint in the proper position. The pelvic band itself should fit closely round the pelvis, just below the iliac crests, much in the same way as does a hernia truss. The connecting piece comes up from the thigh bucket, along the anterior edge of the great trochanter, and the joint is incorporated in this just one and a quarter centimetres above the tip of the trochanter, in line with the centre of the hip joint.

The greatest care must be exercised in satisfying oneself with the fitting of the pelvic band, as, if the joint is not correctly placed, or the thigh bucket not well fitted, the limb cannot prove of its full value to the patient. Soft fat thigh stumps are unsuitable for a leather bucket, owing to the folding-in and puckering of the skin, and in these cases it is more satisfactory if a well-moulded wooden bucket is ordered.

When the limb is being tried on, one must see that the anterior superior iliac spines are in the same horizontal plane, so that the limb may be neither too long nor too short. Six millimetres is the maximum difference in level that may be allowed.

Artificial lower limbs are of much more real value to the patients than are upper limbs, as in the majority of cases, even with amputation through the hip, it is possible for them to walk very well with or without the aid of a stick after a little practice. There is not nearly so much to get out of order in them as with upper limbs, for they present fewer mechanical difficulties, and can be built much more solidly.

The wearers of artificial limbs must exercise constant care and attention in looking after their appliances, and, even so, will be very fortunate if some workshop job does not evince itself within a year or two, for which the State must make provision.

SUB-TERTIAN MALARIA—A REPORT OF THIRTY-FIVE CASES.

By **A. W. Holmes à Court, M.B., Sydney,**

Major, Army Medical Corps, Australian Imperial Force; Honorary Assistant Physician, Sydney Hospital.

The outbreak of malaria here recorded occurred on board His Majesty's Australian Hospital Ship, ———, on a voyage from England to Australia.

These cases, being an isolated group resulting from an infection occurring at a definite time and place, and presenting certain instructive and characteristic features, would appear to be of sufficient clinical interest to justify publication, although perhaps offering nothing unusual to those familiar with tropical medicine.

Source of Infection.

The ship arrived at Sierra Leone during the height of the malarial season, and took up an anchorage well out from the shore, at a distance of 2,000 yards. There were on board 690 persons, of whom 35 became infected by malaria, *i.e.*, 5.06%.

During the evening of the third day in port, a fresh anchorage was taken up 1,139 yards from the shore. An off-shore breeze sprang up, and many mosquitoes were observed on board shortly after nightfall.

As the ship sailed the following day, this was evidently the source of infection, as of the patients who subsequently developed malaria, only one visited the shore at any time. Moreover, this was during the daytime, when mosquitoes are not in evidence in the town.

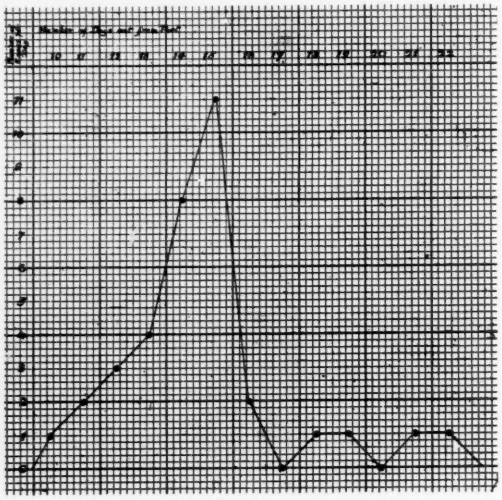
It is stated that 1,000 to 1,500 yards is, under ordinary circumstances, a safe distance to anchor from a mosquito-infected shore (Manson).

Incubation.

Taking this date as the time of infection, it is possible to calculate the incubation period with considerable accuracy. The first case arose 9½ days after leaving port, *i.e.*, 10 days after the arrival of mosquitoes.

The case incidence then increased day by day, until the fifteenth day, and thence diminished until the twenty-second day, when the last case appeared.

The case incidence day by day is graphically represented in the following diagram:—



Assuming that infection occurred on the night indicated, the shortest incubation period was 9½ days, and the longest 22½ days.

It is to be noted that mosquitoes continued to be found on board as long as 30 days after leaving port, so that in the later cases in the series the patients may have been actually infected by these mosquitoes several days later than the earlier patients.

Taking into consideration the fact that the disease had usually well developed before the patients reported sick, the figures are compatible with the usually recognized incubation period for *Laverania malariæ*, which is given by Manson as 10 days and by Castellani and Chalmers as 9 to 10 days.

Type of Parasite.

Malarial parasites were found in 33 out of the 35 cases. In the remaining two patients quinine had been administered before the blood was examined. In these cases the periodicity of the fever and rapid response to quinine allowed the diagnosis to be established.

Morphologically, the parasites corresponded to *Laverania malariæ*, the infective agent in sub-tertian or malignant malaria. This is the type of parasite prevalent on the west coast of Africa (Castellani and Chalmers). Multiple infection of red corpuscles was frequently noted, sometimes three parasites being observed in a single cell. The severity of symptoms in general seemed to correspond fairly closely to the relative number of corpuscles invaded, although the height of the fever did not appear to have so close a relationship to the number of parasites seen in the peripheral blood.

The characteristic crescent gametocytes were found in the peripheral blood on the tenth day of the disease in one patient who recovered, and in the spleen and liver in one case which terminated fatally.

Clinical Characteristics.

Prodromal and initial symptoms were somewhat misleading, the illness being ushered in with coryza, suffusion of the eyes, pharyngeal infection, pains in limbs and general malaise, with an irregular type of temperature. Rigors were infrequent.

Clinically the cases were of very severe type, epistaxis, hiccough, bilious vomiting, choleraic diarrhœa, icterus, and extreme prostration being usually noted. Low delirium was frequently a marked feature.

Many of the more severe cases corresponded closely with the clinical picture of bilious remittent fever, showing severe prostration and cardiac asthenia.

Albuminuria was present in 48.5%. Hæmoglobinuria was not observed. The accompanying charts show the clinical course of the disease and response to treatment.

Treatment.

Intramuscular injections of quinine hydrobromide (0.6 gm. dissolved in 8 c.cm. sterile water with addition of a few drops of *acid hydrobrom. dil*) produced rapid amelioration of symptoms.

Two injections were given into the gluteal muscles at an interval of 18 hours.

Diarrhœa and vomiting then ceased, and rectal or oral administration of the sulphate of quinine was employed.

It is worthy of note that, after two intramuscular injections had been given, not only did the young parasites, merozoöites and young trophozoöites disappear from the peripheral blood, but the gametocytes could not longer be found, although these forms are usually unaffected by quinine (Manson).

Their disappearance from the circulation may, however, have been merely coincident with the injections.

Mortality.

Two patients died in spite of energetic treatment. This is equivalent to 5.7% of the cases.

Both of these patients were already cachectic from other diseases (diabetes and phthisis), so that the malarial infection is to be regarded merely as a terminal event.

A post-mortem examination was made in one of these cases, and parasites found in spleen and liver. Hæmozoin granules were noted in the parenchyma cells of these organs.

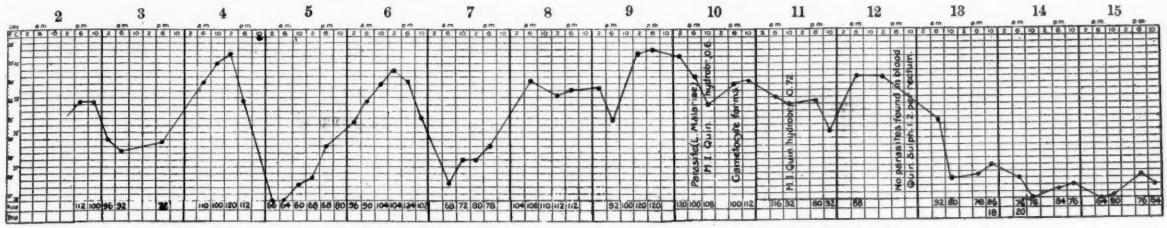
The bone marrow was unusually dark in colour, soft and diffluent; no parasites were observed therein.

Conclusions.

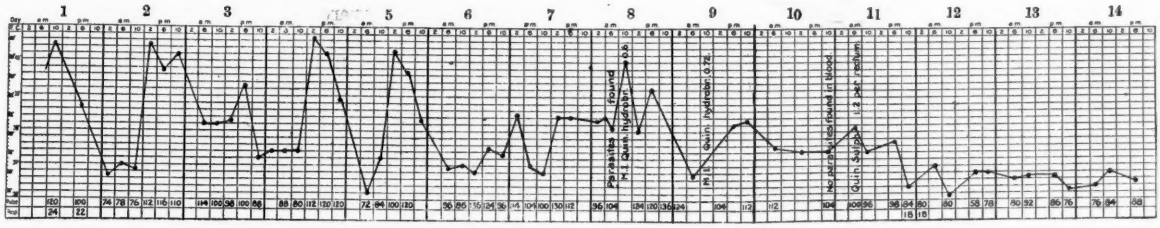
The record of these cases does not purport to give any new information on this subject: it may, however, help to emphasize the importance of early blood examination in doubtful cases of pyrexia, with or without rigors.

Ships lying off malarial shores are not necessarily immune from infection at a distance of 1,130 yards.

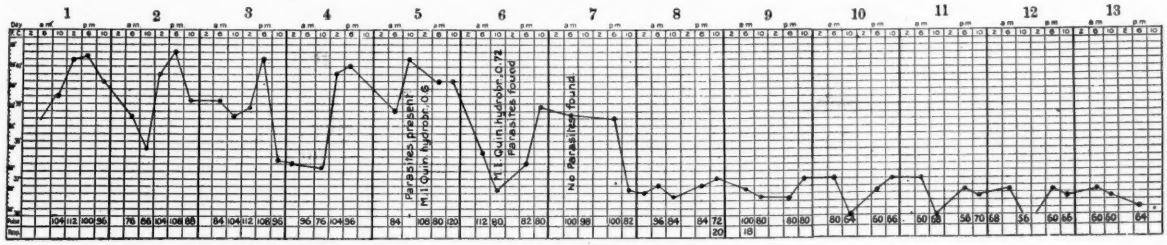
In his report of the voyage to the Director-General of Medical Services, Australian Army Medical Corps, the Officer Commanding troops on the ———, Lieutenant-Colonel T. G. Wilson, made the suggestion that in future hospital ships or transports calling at ports such as Sierra Leone, where malaria is endemic, the ships should be anchored out as far as possible from



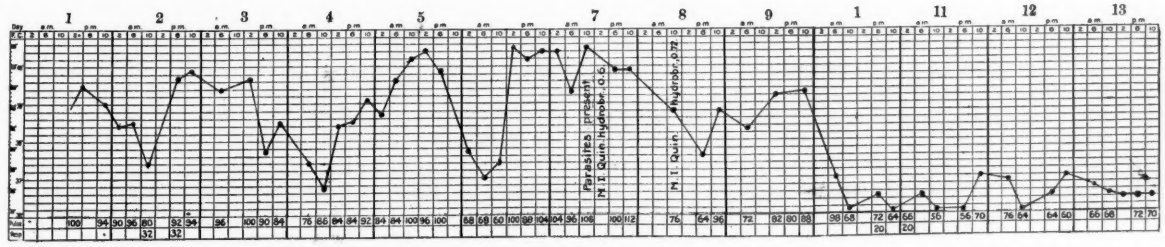
I.—Severe sub-tertian infection with rapid response to quinine.



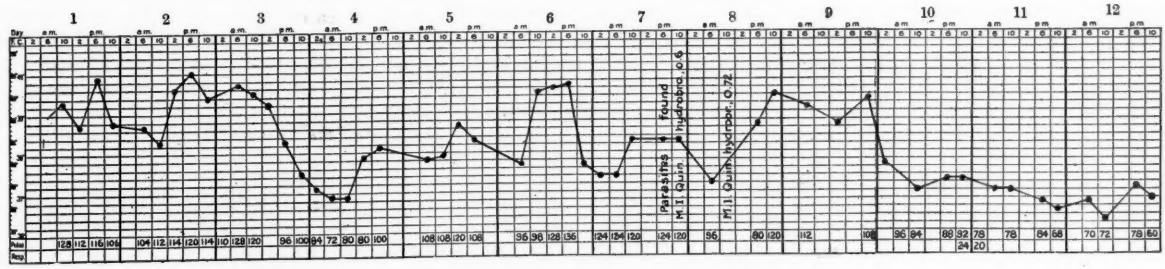
II.—Heavy infection by *Laverania malariae* showing irregular pyrexia.



III.—Quotidian fever.

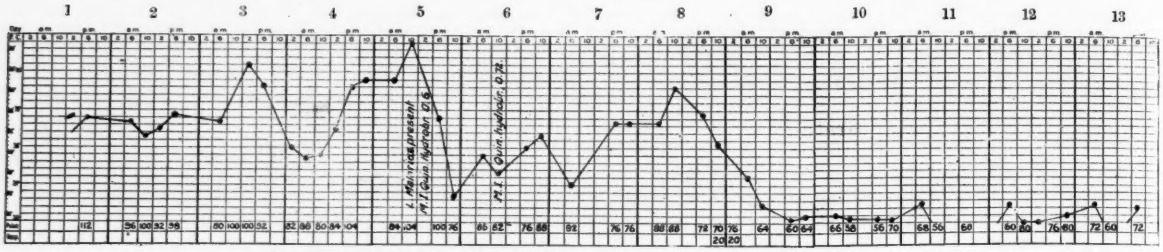


IV.—Irregular fever.

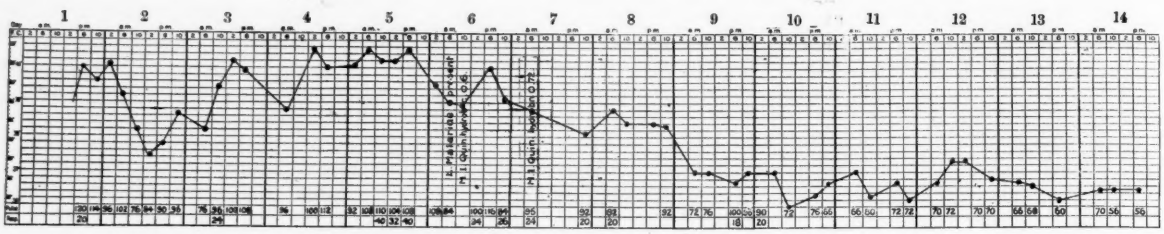


V.—Irregular fever, with pseudo-crises.

M.I.=Intramuscular injection.



VI.—Atypical pyrexia.



VII.—Irregular continued fever with absence of crises.

shore, especially at night time, as mosquitoes are not supposed to be found further out than one mile from the shore.

The intramuscular injection of quinine causes the rapid disappearance of the parasite from the blood, together with immediate improvement in condition of the patient.

No untoward result was observed after any of the seventy injections given in this series, either as result of the operation itself or from the toxic action of quinine.

This method of treatment in sub-tertian infections is rapid, efficacious and devoid of risk if employed with due regard to asepsis and technique.

References.

[1] Manson, Sir Patrick, *Tropical Diseases.*
[2] Castellani and Chalmers, *Manual of Tropical Diseases.*

PERFORATING INJURIES OF EYEBALL BY MAGNETIZABLE BODIES.

By **Guy Antill Pockley, M.B., Ch.M., Sydney,**
Sydney.

There is no doubt that our knowledge will be vastly increased in regard to the treatment of these cases as a result of the war, and that new methods of technique will be evolved for dealing with eyeballs retaining a magnetizable fragment as the result of a perforating injury.

It was pleasing to see an article by Dr. J. Lockhart Gibson in *The Medical Journal of Australia* of December 29, 1917, on the use of the Haab magnet and the discussion which followed at the meeting of the Queensland Branch of the British Medical Association. While the attention of ophthalmologists in Australia is thus attracted to the subject, it struck me that it would be a good time to publish some notes on some cases of my own, and to offer some observations and conclusions which I had been intending to publish, in the hope of arousing some interest in the discussion of the subject. The conclusions formed are necessarily offered in a tentative spirit, and are open to amendment, as the number of cases is too small to justify dogmatism.

In all, I have had experience with 22 cases of perforating wounds of this description, and, of these, all but the last five were tackled with the Haab magnet. The last five were all successfully treated with hand electric magnet, and I am sure that several of the first 17 would have given better results if they had been treated in this way, though I am equally sure many of them gave better results with the giant Haab magnet than could have been secured with the hand magnet.

Unfortunately, detailed history cards of all these cases are not to hand, and so individual results of complete lists cannot be published.

The first essential in approaching an eye with a foreign body in it is accurate localization. Unfortunately, in very few cases can we localize by direct ophthalmoscopic observation, owing to opacities of media, hæmorrhages, exudations, etc. In most cases we have to fall back on X-rays; the results, however, nowadays are very satisfactory. The first successful and at all reliable X-ray localizations I saw were by the Mackenzie Davidson apparatus, but of late I have found the Sweet's apparatus the one which I have no hesitation in trusting. I have known small errors in localization by his method, but very rarely, and have had an eye submitted to as many as three examinations with only 2 mm. variation in the position where the foreign body was localized. Where localization is impossible in remote districts, possibly less

harm would be done by using a giant magnet than by promiscuously making an incision and inserting a hand magnet, but in modern civil practice it would be better to keep the patient a few days till he could be sent to the X-ray apparatus than to attempt by any means to remove the foreign body without accurate localization.

The Giant Magnet.

This should, I think, be as powerful as possible. The one I had access to was reputed to lift 2,000 pounds, and was a very heavy and unwieldly instrument. While in many cases the power of the magnet itself constituted a great danger in several, it failed to extract the foreign body, even in quite recent cases. For the latter reason I think that if one is using a giant magnet, it should be as powerful as possible.

With regard to the foreign body lying in the anterior chamber, in favourable cases it can be extracted through the original wound, which can rarely, if ever, be done with hand magnet.

When a foreign body is entangled in the iris, or immediately behind it, by approaching the patient from a long distance, it can occasionally be freed from iris without iris prolapse or irido-dialysis being caused in the process, but the difficulty in so doing is sometimes great, and one must remember that the force of the magnet cannot be gently applied. Once the switch is on, the full force is applied, with a jerk, as it were. If the foreign body is exactly behind the perforation in the cornea, it can be withdrawn, and, at most, a small prolapse of iris will occur, if it is entangled in the iris. However, I have on several occasions experienced the following difficulty. The foreign body comes forward and pushes the iris up against the back of the cornea. It is impossible to draw it through the iris, and, if entangled in the iris at all, it cannot be safely drawn through the pupil. In fact, any attempt to draw it through the pupil when the lens is not already cataractous, is a very bold step, and, if the surgeon is successful in so doing without injuring the lens, he is very lucky.

This same applies when the foreign body is in the vitreous. I have twice seen cataract produced in an otherwise healthy lens by a foreign body being drawn through the pupil.

Again, in two cases I failed to extract a foreign body which was originally in the vitreous, and which, in the attempt to draw it through the pectinate ligament, became firmly entangled in the ciliary body. In one of these cases the foreign body was afterwards successfully removed through a scleral incision at equator on the opposite side of the globe.

One accident is, I think, worth reporting fully.

The foreign body was localized behind the ciliary body. On the application of the magnet at a distance, pain was felt, but there was no sign of the foreign body coming forward. The patient was brought closer and power reapplied several times, the axis of the patient's eyeball being altered between each application to a small extent. There was a noticeable forward movement of the globe and great pain. The magnet was getting hot, and the attempt was about to be given up when suddenly the foreign body came with a rush and, before the switch could be released, it had perforated the cornea from within and had stuck on the magnet point, surrounded by the complete iris, which it had avulsed on its way forward. The foreign body in question was a fragment of an engine casting from an aeroplane, and was 2½ mm. in its greatest diameter. I can only surmise by way of explanation that the fragment had a blunt edge towards the magnet, and was deeply entangled in the ciliary body, or possibly in the sclera, and that manipulation caused it to turn suddenly and to cut its way out with its sharper edge.

In two cases where hand magnet had previously been unsuccessfully used previous to the case coming under observation (through a scleral incision), the giant magnet was successful, once in drawing the fragment forward through an already cataractous lens into the anterior chamber, and once through the scleral incision made for the hand magnet.

With the ring giant magnet I have had no experience at all, though cases reported by T. Harrison Butler prove it to be a very useful instrument.

In using the "Haab" I have always approached the patient to the magnet, though I believe Haab favours having the magnet suspended above the head of his patient, so as to enable the operator to control any sudden movement of the patient on feeling pain, by having him on a table. It also makes it easier for any other surgical technique, such as opening the anterior chamber or dealing with a prolapse.

The Hand Magnet.

This appeals to most ophthalmic surgeons as being much more a weapon of precision than the giant magnet, but unfortunately it has not the power to be universally successful. I have extracted many foreign bodies from both the anterior and vitreous chambers with this, from the latter as long as three months after its entry, and I think with much less risk than with the Haab magnet. However, I have failed with the hand magnet and later succeeded with the "Haab," as stated above.

Much has been written about the incisions in the sclera and retina necessary to extract with the hand magnet being the cause of detachments, but opinion does not seem to be at all general on this point. I can only say that I have seen detachments both as immediate and late results of extractions with the Haab magnet from the vitreous to the anterior chamber.

I have tentatively come to the following conclusions:—

(*a*) It is usually best to remove foreign bodies in the anterior chamber by means of a hand magnet through a lineal incision. If they are difficult to remove with the hand magnet, a "Haab" magnet should be used, but not unless.

(*b*) When the foreign body is in the posterior chamber, an attempt should be made to draw it into the anterior chamber through the original wound in the iris, or if the lens is already cataractous, through the pupil, with the giant magnet. If the lens has escaped and the foreign body is entangled in the posterior surface of the iris, I would be inclined in the future to use the "Haab" as an aid to localization by bulging the iris and then do an iridectomy to enable the foreign body to be drawn forward by the magnet, if it is not removed in the piece of iris, without danger to the lens.

(*c*) When the foreign body is in the vitreous and the lens is already cataractous, an attempt to draw

it forward into the anterior chamber should be made with the giant magnet.

If the lens has escaped, an attempt to remove it through a scleral incision by the hand magnet should be made, and if this is unsuccessful, an attempt should be made with the giant magnet through the same incision.

I might, before closing, refer to a most interesting article continued through several numbers of last year's *Ophthalmoscope* by W. Barrie Brownlie, in which he not only reports 50 interesting cases, but, what is much more instructive, gives results two years after the operation. In this I was struck with the following facts:—

The giant magnet in his hands was almost always successful in bringing the foreign body into the anterior chamber, when the wound of entry was corneal. When the wound of entry was scleral, the operator only succeeded in a small proportion of cases in extracting it into the anterior chamber, but usually he succeeded later in extracting it through a scleral incision.

With regard to cases where the foreign body cannot be extracted by any means and a functionating eye is left, we always have a very difficult question to decide whether it is safe to leave the eye or not.

I have two cases in which a foreign body has been in the globe; in one case for three, in the other for two, years, with no apparent harm beyond slight siderosis. In one, vision, with a small correction, is $^{6}/_{6}$, in the other, in which the lens was destroyed, vision with + 10 sph. is $^{6}/_{9}$.

I think the war cases will give us wonderful information on the safety or otherwise of leaving such eyes alone, in the course of a few years.

Reviews.

MALINGERING.

Sir John Collie has produced a second edition of "Malingering and Feigned Diseases" to bring up to the level of present events his work on the same subject published in 1913.[1] To a great extent the subject matter has been rewritten, especially the chapters on nervous diseases, and considerable additions have been made. The author points out that until the accident insurance for workmen came into vogue, the study of malingering was practically confined to those in charge of naval and military establishments. As a definition of malingering we are told that according to Lord Justice Buckley it is the cult of "one who is not ill and pretends that he is." It is recognized by most authorities that pure malingering is not common, and that the majority of cases have just enough genuine incapacity or disease present to make the diagnosis difficult. Sir John Collie refers to Byron Bramwell's distinction between malingering and valetudinarianism, the latter being a morbid anxiety concerning the health. After an accident, while the insurance pay is sweetening convalescence, there seems a disinclination on the part of the workman to declare himself ready to make a try to return to work. These individuals the author calls the "lingerers on the threshold of work," and it is in these cases that the battle of wits brings out the cunning of the patient on the one hand, and the skill of the medical man on the other. The National Insurance Act and the Workmen's Compensation Act have quite altered the attitude of the workman towards returning to work after an illness or accident. If a workman belong to several clubs and an insurance company, he can draw a bigger wage when incapacitated than when he is working, so that the temptation to delay the return to work is very powerful, and frequently prolongs the convalescent stage until the once strong workman becomes flabby, mentally and physically. The author therefore, advises as early a return to work as is compatible with health. The trouble is that the ordinary workman all the world over is not an educated being, and cannot judge his own position correctly. His thoughts are of compensation rather than of return to health and efficiency. The chapters on how to conduct a medical examination in cases of claims for injury are useful and full of advice gathered from the experience in the examination of many thousands of claimants. Stress is laid upon the advantage when examining applicants for entrance to companies and public services, of obtaining an answer to the question: "Are you now in good health?" This fixes the duration of any disability subsequently complained about. In the chapter dealing with the integrity of heart muscle there are clearly stated rules which are somewhat comforting after the many expressions of opinion appearing in the journals concerning the recruit's heart. As these rules were written after consultation with Sir James Mackenzie, they will be of immense value, to army officers in particular. In the section dealing with hysteria the author states that this condition is unknown among barbaric races. If "ideas controlling the mind" is a short way of expressing the cause of hysteria then "pointing the bone," or *pourri pourri*, are distinct manifestations of hysteria found amongst the blacks. Another statement the author makes is "personally I never investigate the previous history of anyone sent for medico-legal examination, on account of the unreliability of the statements." It does not seem clear why the fact that the patient is being examined for medico-legal purposes should dispense with a very important help in diagnosis. The author quotes rather a neat way of expressing the mental condition in cases of hysteria. He says:. "The patient says 'I cannot,' the friends say 'she will not,' and the doctor says 'she cannot will.'" There are useful tests collected for the examination of the special senses, and these are practically a synopsis of all the known tests that would be of any value in the detection of malingering. One of the striking features of the book is the thoroughness with which every section is discussed. Chapter 22 is devoted to military malingering, and deals with such problems as the difference between self-inflicted wounds and wounds received from the enemy. As the author states, there is no necessity for a soldier to run the risk of being detected in blowing off his own fingers. By holding up his hand over the trench the enemy will do that for him. There is a long description of the excuses and dodges made use of by those trying to avoid military service. Many of the excuses are without the least justification, but as Sir John Collie puts it: "There are always men born lazy, or born gun-shy, who have to be dealt with and made the most of."

The subject of insanity, as a variety of malingering, is clearly and pithily expressed, its only fault being the short space allotted to a subject which crops up in nearly every trial of a capital offence. The author expresses a rather shrewd opinion in regard to the effect of giving convalescent patients, military and civil, too much sympathy and fussy attention. He thinks that patients should be encouraged to discard crutches and sticks as soon as possible, and not to come under the influence of the too sympathetic atmosphere of the voluntary aid hospitals, which is the unintentional cause of much exaggeration and delayed convalescence. There is a chapter on the question of privilege and the conduct of medical witnesses, and naturally there are several chapters in which the medical aspect of the Workmen's Compensation Act and the National Insurance Act is discussed. There is a good index, which adds to the value of a work of this nature. The index is amplified by the last chapter of the book. This contains a collection of eponymic signs which are frequently used in the description of medical examinations. The work is of value to all medical men both as a reference and a descriptive study of the individual who practises malingering.

[1] Malingering and Feigned Sickness, with Notes on the Workmen's Compensation Act, 1906, and Compensation for Injury, including the Leading Cases Thereon, by Sir John Collie, M.D., etc.; 1917. London: Edward Arnold. Demy 8vo., pp. 664. Price, 16s. net.

The Medical Journal of Australia.

SATURDAY, JANUARY 26, 1918.

The Randwick Hospital Enquiry.

The enquiry by a civil body of politicians and business men into the administration of the No. 4 Australian General Hospital at Randwick, and the action taken by the Minister for Defence as a direct outcome of the reports of this committee, are matters of great importance to the medical profession. We have refrained from dealing with this matter until the present time, because we recognized that the interests of the medical profession would be better served if a full record of the evidence given at the enquiry were before us. The committee, or some of its members, have, for reasons best known to themselves, not submitted the evidence in detail. It has therefore become necessary for us to attempt to analyse the reports and to call attention to the questions involved with the scanty information vouchsafed the public at our disposal. The main facts may be recapitulated as follows: A body of ten persons, nominated by public bodies having no remote connexion with hospitals, the medical profession or the maintenance of military discipline, were charged by the Minister for Defence to enquire into the administration of a military hospital. The committee was obviously incapable of conducting a satisfactory enquiry into the subject referred to it, because not one of its ten members had any knowledge of the subject. It is inconceivable that the Minister should have included in the terms of reference that the committee should act as a disciplinary body or court and enquire into the relationship of the Principal Medical Officer of the No. 2 Military District and his subordinate officers in the Hospital. From the report, however, it is quite clear that the committee did concern itself with disciplinary matters. Since this is a gross infringement of a military function, it becomes the duty of the Minister to reprove the committee and to refrain from utilizing its services in the future.

The committee submitted to the Minister for Defence two reports, each signed by five members. These two reports are so contradictory and so transparently dictated by a desire to interpret the available evidence in a preconceived manner, that neither could be justly used as the basis for any action. Nevertheless, the Minister has thought fit to dismiss from their posts three prominent officers. It will be noted that the dismissal is unaccompanied by any charge, so that they have no remedy under military law by appealing to a court martial. It is useless to endeavour to discern from the reports or from the scraps of evidence, clumsily selected to give a semblance of support to the findings, the truth about the efficiency of the administration of the No. 4 Australian General Hospital. The committee did not possess the necessary knowledge to conduct an impartial enquiry, and we are tempted to surmise that it was indifferent to the soundness of its conclusions. We are deeply concerned with the welfare of soldiers who are entrusted to the care of members of the medical profession. From the reports of the committee we have learned nothing that would justify an expression of opinion. With the alleged friction between the Principal Medical Officer and the Officer Commanding the Hospital we cannot deal, since this is entirely a matter for a properly constituted military tribunal. If any friction existed, as the committee appears to have believed was the case, it would have been dealt with in this manner.

From the military point of view the question of the proper administration of a hospital should not have been referred to a civil body, and certainly not to an inexpert civil body. Medical practitioners have responded magnificently to the call, and many have willingly faced the necessary sacrifices. All recognize when joining the Australian Army Medical Corps or the Reserve that they will be required to carry out their duties in conformity with the army regulations. When a practitioner is selected for a post of special responsibility, he should not be subjected to interference or control by any but his superior officers. In Great Britain the control of the medical services is vested entirely in the Director-General, and the War Office never intervenes between the Director-General and those under his charge, save by way of recom-

mendation. Each medical officer is held responsible for the satisfactory discharge of his duties, and inefficiency, neglect or other defect is dealt with by his superior officer. In practice, the Director-General assumes the direct responsibility of the whole service, and we have yet to learn of a single instance in which either the War Office or any lay body relieved him of this control. In Australia, it appears that the Minister for Defence, a politician who is here to-day and may be gone to-morrow, has usurped the control which properly belongs to the Director-General, and has misused his constitutional right by interposing a civil committee between the Director-General and his subordinate officers. Such a condition of affairs is intolerable. The services of medical officers are limited in their utility, and the reputation of the whole organization is endangered. Moreover, medical practitioners are willing to entrust their reputations to the care of the huge military authority, but cannot agree to be judged by a body of irresponsible politicians.

Incidentally, the question of the conditions in which medical officers are appointed to positions of great responsibility within the Commonwealth is opened up by the events connected with the Randwick Hospital enquiry. This matter must, however, be dealt with on another occasion, since it arises as a result of the action of the Minister rather than as a direct outcome of the appointment of the committee and its utilization for the purpose of the enquiry.

The medical profession has further reason to be extremely apprehensive. If the Minister for Defence can refer a matter of the proper administration of a military hospital by a medical officer to an incompetent civil body, there is a grave danger that this may be taken as a precedent for submitting medical superintendents and other medical officers connected with civil hospitals to the critical control of lay persons, who have no experience in hospital administration. No medical officer would be safe. It is freely admitted that the lay members of hospital boards are competent to safeguard the interests of the community, if indeed any such safeguarding is needed. Experience has shown that the medical profession should have ample representation on hospital boards of management, and that in all matters involving professional knowledge, the boards should be guided by medical practitioners. All disciplinary bodies which deal with alleged breaches of professional behaviour must either be composed wholly of medical practitioners or be properly constituted courts of law. The medical profession must resist with all its power any proposal or precedent which would have the effect of subjecting it to the control of politicians or meddlesome civil committees. We therefore utter an emphatic protest against the reference of the question of the proper administration of the No. 4 Australian General Hospital by the Minister for Defence to the Advisory Committee for Military Hospitals and Convalescent Homes in New South Wales. We protest against the fact that the Minister has taken action as a result of the reports of this committee. And, lastly, we protest against the unwarranted slur which has been cast on the honour of the medical profession.

VOCATIONAL RE-EDUCATION IN CANADA.

While Australia is waiting and apparently considering the best means of again rendering her disabled soldiers a national asset, definite schemes have been adopted in other parts of the Empire, and departments have been organized to carry out the details. We have dealt on several occasions with some aspects of the system now in force in Great Britain. In South Africa the problem has been attacked by giving every disabled man who is unlikely to regain sufficient functional activity to enable him to return to the firing line, the opportunity of receiving professional re-education. The soldier is kept under military discipline during the whole course of re-education. In the majority of cases this is carried out at the South African Military Hospital in Richmond Park, close to London. As soon as the commanding medical officer of this hospital reports that the man is not expected to become fit for further service, the re-education is begun. The training has been made so tempting to the men that over 90% of those recommended to undergo it, have seized the opportunity. Since the re-education is begun early, it is not surprising to learn that marked success has accompanied the efforts of the instructors. The men are not discharged from the Army until they have returned to South Africa, and during the whole time they are subject to military discipline.

In Canada, disabled soldiers receive a certain amount of training during convalescence prior to their discharge. As soon as it is determined that they are unfit to follow their previous occupations, they receive their discharge and the so-called vocational re-education is then begun. The vocational

or physical training given before discharge is largely therapeutic in its object. The patient is under military discipline and is required to carry out the instructions of the medical officer in charge. He has to select one or more than one branch of study or occupation. The subjects include clerical work, arts and crafts, mechanical drawing, gardening and poultry rearing. The selection is voluntary on the part of the patient, although he must choose something. The medical officer then determines whether the choice covers an occupation which will supplement the treatment to a useful extent. He prescribes the number of hours daily during which the patient has to attend the classes. The instructors are under the direction of the district vocational officer. At the same time a course of physical training is carried out, if the medical officer approves of it. The vocational officer considers each case carefully and a thorough survey is made of the man's capabilities, in order that the second stage of his training may be wisely inaugurated.

As soon as the medical officer reports that the man will not be able to follow his previous occupation, the district vocational officer refers the case to a board, called the Disabled Soldiers' Training Board. This body reports on the case to headquarters in Ottawa. There is a medical man serving on this board. If the recommendations of the board receive the approval of the headquarters' staff, the vocational officer has the duty of carrying them out.

The machinery which has been provided throughout the Dominion includes primary hospitals, convalescent hospitals, an orthopædic centre, an artificial limb factory, clinics for neurasthenics, sanatoria for consumptives and technical institutes and schools for re-education. For the purposes of medical and surgical treatment of returned disabled soldiers or those who have become disabled while on service in Canada, there is accommodation for about 7,000 patients. A very large number of public and private buildings have been erected or adapted to this purpose. Extension is being undertaken, in order that accommodation may be found for all men on their return from the front. The last stage of the vocational re-education embraces the employment of disabled men in the callings in which they have been freshly trained. Much of the information given above has been gathered from special official reports published in *Recalled to Life*.

CANCER OF THE LOWER BOWEL.

There are few branches of surgery in which greater divergence of opinion exists than that dealing with malignant disease of the rectum and colon. All appear to be agreed that early removal of the involved area, including the lymphatic vessels and glands, offers the patient a fair chance of recovery. The difficulty, however, begins even in the interpretation of this doctrine. The diagnosis of rectal or colonic cancer at an early stage may be a matter calling for considerable skill and thoroughness on the part of the surgeon. Moreover, the patient is not often inclined to seek the advice of a surgeon while his symptoms are slight and the physical signs obscure. Those who advocate an exploratory operation for the purpose of making a diagnosis assume that signs or symptoms are present which indicate to the patient or doctor that there may be some serious affection of the bowel. In the present state of our ignorance it is unfortunate that a surgeon is compelled at times to grasp his knife before he has ascertained what is the matter with the patient. Much careful observation and research is needed before surgery can be transformed from an art into an exact science. In the case of manifest malignant disease of the rectum, the diagnosis can be made tentatively from signs and symptoms and confirmed by the microscopical appearances of a portion of the tumour. At this stage the chances of freedom from recurrence for a number of years or permanently are variously assessed by different authorities. There are some who hold that the condition is so fatal that it is not worth while to remove the growth. They elect to perform colostomy in the hope of diminishing the sufferings of the patient and prolonging his life. On the other hand there are many sanguine surgeons who undertake extensive radical operations, believing that this procedure is justified by a reasonable chance of prolonged immunity from symptoms and even of complete cure. This divergence of opinion and practice should not exist, since it is possible to ascertain the fate of patients subjected to the various operations employed in the treatment of malignant disease of the lower bowel. Unfortunately the records of cases are usually published in a manner which makes it difficult to find a reply to the question raised. Dr. Jerome M. Lynch, who has dealt with a large number of cases, gives some information of value, although his statistics are not arranged in such a way that the prognosis after operation can be assessed.[1] Of his 491 patients, 304 were treated by radical excision. Of these 51 died as a result of the operation. The operative mortality was therefore 16%. Palliative operations were performed in 41 instances. He claims that 26% of his patients were alive three years after the time he had them under his care. The duration of life after operation varied up to 16 years. The information needed to determine whether a radical operation offers material advantages to the patient, covers a wider range. Since it is practically impossible to fix the time of the beginning of the disease, for the sake of comparison the appearance of the first symptom should be recorded in every case. The duration of life in cases in which surgical advice is sought late and in which firstly no operation is performed and secondly a palliative operation is undertaken, should be compared with the duration of life after complete removal. It would be well to distinguish between cases needing the removal of other organs and those in which radical excision does not involve more than the bowel and pelvic tissues. The figures for the rectum, sigmoid and colon should be kept distinct, for there are anatomical and develop-

[1] *The Journal of the American Medical Association*, November 24, 1917.

mental reasons for concluding that the rapidity of growth of a neoplasm differs in these regions. In addition it is essential to ascertain the length of time of freedom from recurrence and the duration of life after recurrence. Information is available which tends to suggest that the power of a radical operation to cure a manifest malignant tumour of the lower bowel is very small and that the average length of life from the first appearance of signs or symptoms until death is but slightly in favour of those who have undergone radical treatment.

CRAW-CRAW.

Castellani has given a description of a skin disease which he met with in Ceylon among the natives, and which he called craw-craw. This affection occurs in Africa and in other tropical countries. We are unaware whether it has been observed in Papua or Northern Queensland. It is characterized by the presence of hard papules varying in size from 3 to 8 mm. The papules are round and somewhat flattened. They are slightly more pigmented than the normal skin. The whole body, save the soles of the feet and the palms of the hands, may be affected. Castellani has stated that the face is not involved, but other observers are not in accord with him in this respect. When the rash extends to the face, suppuration may occur as a result of infection through scratched wounds. The patient complains of itching and of a burning sensation. There are no constitutional symptoms. Dr. A. Pijper[1] has availed himself of an opportunity of studying the ætiology of this affection. All accounts of the disease demonstrate that it is quite distinct from coolie-itch. Pijper was able to show that it was not a syphilitic manifestation. Spirochaetes could not be found in the lesions and iodide of potash had no effect on the rash. Microscopically it is seen that the papule is composed of epithelial cells. The papillary layer of the skin is hyperæmic and there is an infiltration with polynuclear leucocytes. Pijper failed to find any micro-organisms in his sections, but he recognizes that it is usually difficult to demonstrate bacteria in this manner. Cultural experiments yielded a plentiful growth of a polymorphic non-motile bacillus. This bacillus is slightly curved and slender and had swollen ends. It does not contain any spores. It stains readily with Löffler's methylene blue. Roundish granules are seen when the bacilli are stained by Neisser's method. The bacilli are Gram-negative. It thus appears that the organism is indistinguishable morphologically from diphtheria bacilli. The cultural characteristics caused the author to class them among the diphtheria group of organisms. He endeavoured to reproduce the human lesions in animals. Hard papules were produced in the ear of a rabbit from seven to fourteen days after the injection of small quantities of the bacilli. The papules had all the characteristics of the human lesions. He therefore concludes that the cause of craw-craw is a coryne-bacterium.

[1] *The Journal of Tropical Medicine and Hygiene*, November 1, 1917.

Naval and Military.

CASUALTIES.

The 380th list of casualties, which was issued to the public on January 21, 1918, contains information regarding the fate of a large number of men who have been posted missing. Unfortunately, many of these have been killed in action, or have died as a result of injuries. There are 46 names of officers in the list, including one medical officer. Captain James Iver McIver Chirnside is reported to be ill.

HONOURS.

The following decorations have been given to members of the Australian Army Medical Corps.

Captain George Vernon Davies has received the Distinguished Service Order.

Captain David Macdonald Steele has received the Bar to the Military Cross.

The following have received the Military Cross:—

Captain Archibald John Collins.
Captain Eric Macallan Gordon Glassford.
Captain Hugh Edward Kirkland.
Captain Guy Ardlaw Lawrance.
Captain John Shaw Mackay.
Captain Melrose Holtom Mailer.
Captain Harold Powell.
Captain William Dempsey Quilty, and
Captain Clive Frederic Robinson.

APPOINTMENTS.

The following appointments, promotions, etc., have been announced in the *Commonwealth of Australia Gazette*, No. 4, of January 12, 1918:—

Army Medical Corps.

To be Colonel:—

Sir Alexander MacCormick, whilst acting as Consulting Surgeon, British Expeditionary Force, 1st August, 1917.

To be Captains—

Honorary Captain H. W. Franklands, Australian Army Medical Corps Reserve. Dated 13th December, 1917.

Honorary Captain F. E. Broadbent, Australian Army Medical Corps Reserve. Dated 3rd December, 1917.

Honorary Captain J. L. Diggle, Australian Army Medical Corps Reserve. Dated 6th December, 1917.

Honorary Captain W. J. Trewhella, Australian Army Medical Corps Reserve. Dated 2nd April, 1917. (This cancels the notification respecting date of appointment of this officer which appeared in Executive Minute No. 427/1917, promulgated on page 1420 of *Commonwealth of Australia Gazette*, No. 107, of 5th July, 1917.)

Robert Mervyn Shaw and Ronald Farquharson Le Souef. Dated 11th December, 1917.

Noel Armstrong Maclure. Dated 12th December, 1917.

James Riddell Bell. Dated 18th December, 1917.

Jack Rail Robertson. Dated 19th December, 1917.

Termination of Appointments.

The appointments of the undermentioned officers are terminated from dates stated opposite names:—

Lieutenant-Colonel J. H. Phipps, D.S.O.—9th November, 1917.
Lieutenant-Colonel E. R. White—12th October, 1917.
Major H. R. Catford—11th December, 1917.
Major W. E. Davies—19th July, 1916.
Major A. S. Clowes—5th December, 1917.
Major R. E. McClelland—9th December, 1917.
Major A. E. Colvin—22nd December, 1917.
Major L. Cowlishaw—27th December, 1917.
Captain F. R. Longden—14th March, 1916.
Captain P. W. Hornabrook—5th December, 1917.

Australian Military Forces.

1st Military District.

Australian Army Medical Corps Reserve—

Honorary Captain F. Russell to be granted temporary rank and pay of Major at rate prescribed by Financial and Allowance Regulation No. 340 whilst employed at No. 6 Australian General Hospital and as member of Permanent Medical Referee Board. Dated 1st January, 1918.

2nd Military District.

Australian Army Medical Corps—

Captain R. Beith is transferred from Australian Army Medical Corps, and to be Captain (temporarily). Dated 1st November 1917.

Australian Army Medical Corps Reserve—

The resignation of Honorary Captain K. Byrne of his commission is accepted. Dated 18th December, 1917.

3rd Military District.

Australian Army Medical Corps Reserve—

James Leslie Diggle and George Henry Wickens to be Honorary Captains. Dated 1st December, 1917.

Stanley Cochrane and Milton Leonard Coutts to be Honorary Captains. Dated 15th December, 1917.

4th Military District.

Australian Army Medical Corps—

Temporary Lieutenant-Colonel A. J. Meikle to be Officer Commanding No. 15 Australian General Hospital and President Permanent Medical Referee Board, with pay at rate prescribed by Financial and Allowance Regulation No. 340. Dated 13th December, 1917.

Australian Army Medical Corps Reserve—

Leonard James Pellew to be Honorary Captain. Dated 15th November, 1917.

The appointment of Honorary Captain H. V. Franklands as Honorary Major (temporarily) is terminated. Dated 12th December, 1917.

5th Military District.

Australian Army Medical Corps Reserve—

John Theodore Anderson to be Honorary Captain. Dated 3rd December, 1917.

His Excellency the Governor-General, acting with the advice of the Federal Executive Council, has been pleased to approve of the following promotions, etc., being made for specially meritorious service during the present war, dated 24th September, 1917:—

To be Brevet Lieutenant-Colonel:—

Major G. W. Barber, D.S.O., Australian Army Medical Corps.

Major W. W. Hearne, D.S.O., Australian Army Medical Corps (since deceased).

Captain (Honorary Major) Sir R. N. Howse, V.C., K.C.B., Australian Army Medical Corps Reserve.

To be Brevet Majors:—

Captain A. R. Clayton, Australian Army Medical Corps.

Honorary Captain W. J. W. Close, Australian Army Medical Corps Reserve.

An announcement was made in London on January 14, 1918, to the effect that Colonel Thomas Herbert John Chapman Goodwin, C.M.G., D.S.O., had been appointed to succeed General Sir Alfred Keogh, K.C.B., as Director-General Army Medical Services. Colonel Goodwin was born in 1871, studied medicine at St. Mary's Hospital, London, and qualified in 1892. He passed into the Royal Army Medical Corps in 1893, and at the outbreak of war had the rank of Major. He was given charge of hospitals and field ambulance work, and during the past 12 months has been acting as Assistant Director of Medical Services.

Sir Alfred Keogh was born in 1857 and is, consequently, in his 61st year. He has had a very distinguished career, and enjoys the full confidence of the medical profession in Great Britain. He gained a very wide experience and performed eminently valuable work in the Indian Medical Service, in which he eventually rose to the position of Director-General. During the South African War he was in charge of a general hospital, and was an officer of the Royal Army Medical Corps. He was mentioned in despatches, obtained the Queen's Medal, and was created a Commander of the Bath with four clasps. In 1904 he was appointed Director-General Army Medical Services, a position which he held for five years. Two years after his appointment he received the honour of knighthood. He had also held the position of Honorary Physician to His Most Gracious Majesty the King. In 1914, when Great Britain entered the war, he was again entrusted with the command of the Army Medical Service. Those who have had an opportunity of gaining first-hand experience of the Royal Army Medical Corps, have been greatly impressed by the excellence of his organization and by the skilful manner in which he overcame countless, almost insuperable difficulties. As is inevitable in the case of a man holding the position of great and grave responsibility, he has been subjected to much pitiless criticism. While we recognize that it is a bold thing to form a judgement of current events 13,000 miles away from the seat of action, we are inclined to the opinion that the Medical Services will suffer harm as a result of the retirement of this excellent officer.

Public Health.

NEW SOUTH WALES.

The following notifications have been received by the Department of Public Health, New South Wales, during the week ending January 12, 1918:—

	Metropolitan Combined District. Cs.	Dths.	Hunter River Combined District. Cs.	Dths.	Rest of State. Cs.	Dths.	Total. Cs.	Dths.
Enteric Fever	13	0	2	1	15	1	30	2
Scarlatina	16	1	2	0	8	0	26	1
Diphtheria	40	4	6	0	24	0	70	4
C'bro-Spl. Menin.	2	0	1	1	1	1	4	2
*Pul. Tuberculosis	31	7	0	0	0	1	31	8

* Notifiable only in the Metropolitan and Hunter River Districts, and, since October 2, 1916, in the Blue Mountain Shire and Katoomba Municipality.

VICTORIA.

The following notifications have been received by the Department of Public Health, Victoria, for the week ending January 13, 1918:—

	Metropolitan. Cs.	Dths.	Rest of State. Cs.	Dths.	Total. Cs.	Dths.
Diphtheria	39	1	19	0	58	1
Scarlatina	23	1	19	1	42	2
Enteric Fever	3	0	11	0	14	0
Pulmonary Tuberculosis	24	7	10	2	34	9
Cerebro-spinal Meningitis	1	—	1	—	2	—
Poliomyelitis	7	—	2	—	9	—

SOUTH AUSTRALIA.

The following notifications have been received by the Central Board of Health, Adelaide, during the week ending January 5, 1918:—

	Adelaide. Cs.	Dths.	Rest of State. Cs.	Dths.	Totals. Cs.	Dths.
Diphtheria	2	0	14	2	16	2
Scarlatina	1	0	13	0	14	0
Pulmonary Tuberculosis	3	3	5	4	8	7
Erysipelas	1	1	4	0	5	1
Enteric Fever	0	0	4	0	4	0
Morbilli	0	0	3	0	3	0
Cerebro-spinal Meningitis	0	0	1	0	1	0

TASMANIA.

The following notifications have been received by the Department of Public Health, Tasmania, during the week ending January 5, 1918:—

Disease.	Hobart. Cases.	Launceston. Cases.	Country. Cases.	Whole State. Cases.
Diphtheria	5	1	9	15
Enteric Fever	1	0	2	3
Scarlatina	0	0	1	1

Abstracts from Current Medical Literature.

MEDICINE.

(29) Incipient Scurvy.

D. J. Milton (*Cleveland Med. Journ.* August, 1917) discusses the records of several cases of incipient scurvy. The classical clinical picture of this condition was not present in any of his patients. The diagnosis would have been impossible in two of his cases, had it not been for the prompt recovery following the administration of orange juice or potato and the addition of fresh milk to the diet. Even when the condition is pronounced, the course may be irregular. There may be only one prominent symptom. Hæmaturia, bleeding from the nose, anæmia, pallor, fretfulness or cessation of gain in weight may be the only manifestation. The author refers to the classification of A. F. Hess. He recognized (*i.*) subacute scurvy, in which the symptoms were incompletely developed, and (*ii.*) latent scurvy, distinguished by stationary weight, pallor, anorexia and a general want of well-being. These signs disappear rapidly under antiscorbutic treatment. He holds that these indefinite types of scurvy are not uncommon. They may progress until the gross features of the disease are manifest, or the signs may disappear spontaneously. The ætiological factors should be borne in mind. They include the age of the patient (from the 6th to the 20th month), and the ingestion of certain forms of food. Boiled or sterilized milk may cause the disease. Repeated pasteurization of milk appeared to have been responsible for it in several of the author's patients. The medical officers in the milk depôts in Paris deny that scurvy is produced by feeding infants on pasteurized milk. The author incriminates malted foods and food containing an excess of carbo-hydrates, peptonized milk, milk that has been overdiluted and certain proprietary foods. According to Hess Czerny's exudative diathesis predisposes infants to scurvy. The author has found that Hess's capillary resistance test of value in the diagnosis. The test is carried out by applying a blood pressure band to the infant's arm and maintaining the pressure for three minutes. When the band has been removed, and the discolouration has faded, petechiæ are found in the scorbutic infant. Other signs of diagnostic importance are increased knee jerks, unusual pallor, œdema of the lower limbs, slight fever, indefinite tenderness, duskiness without hæmorrhage or sponginess of the gums and bleeding after applying deep pressure or friction to the gums. In addition anorexia, slow gain or failure to gain in weight, an unexplained nervous excitability, fretfulness and restlessness are also associated signs. Hess described a rapid pulse and respiratory rate, associated with enlargement of the heart toward the right in connexion with scurvy. The author has not observed this syndrome nor a white line in the skiagram at the epiphysis of the bones which has been described by Fraenkel as one of the earliest signs of scurvy. The author advises that all infants fed on foods capable of causing scurvy, should receive orange juice even as early as the third month.

(30) Chronic Aspirinism.

W. F. Stiell records a case of chronic aspirin poisoning in a lady, aged 50 years, who had for 13 years suffered from rheumatoid arthritis (*Practitioner*, September, 1917). Aspirin had been administered for the first time in 1910. The relief was so striking that the patient had taken 0.6 gramme of the drug twice daily for seven years. She had noticed that the action was more certain when the drug was given mixed with *pulv. tragacanth. composit*, than when taken in tablet form. A slight diminution of the dose, unknown to the patient, resulted in almost complete incapacity to perform voluntary movements. No untoward sign appeared for six years. In January, 1916, an intractable simple conjunctivitis developed. There was hyperæmia of the palpebral and ocular conjunctiva, slight chemosis and marked lachrymation. The aspirin was discontinued, but as the arthritic symptoms became accentuated, it was recommenced. A week later urticaria gradually developed. No relief was obtained by dieting or by the application of local or internal remedies. The rash spread rapidly and the patient's condition became alarming. She had diarrhœa, vomiting, massive œdema of the tongue and fauces and dysphagia. An intense bluish-violet reaction was obtained in the urine with perchloride of iron. The aspirin was withheld and ichthyol, arsenic, belladonna, calcium lactate and bromides were given. At the end of the seventh week all traces of the urticaria had vanished and the urine was normal. Notwithstanding the fact that no further aspirin has been taken, all the rheumatic symptoms, save the bony deformities, disappeared, with the onset of the urticaria and have not reappeared.

(31) A Cause of High Blood Pressure.

Edgar F. Cyriax (*Practitioner*, November, 1917) has arrived at the conclusion that a very common cause of high blood pressure is to be found in irritative states of the *erector spinæ*. By the *erector spinæ* he means all the extensor muscles of the back from the sacrum to the occiput. He divides these irritative states into three groups. The first is hypertonus. Increase of the normal curve forward in the lower cervical region is stated to be the result of persistent muscular contraction. Normally, no difficulty is experienced in relaxing the extensor muscles of the back, when the patient lies on his face. In hypertonus it is difficult or impossible to obtain relaxation, and when it is obtained a slight touch causes a continued powerful contraction. The second group is diffuse fibrosis, which he regards as a frequent cause of rigid back. There is limitation of movement, with pain and diffuse tenderness in the muscles. In addition, nodular thickenings of the neck are met with. The third group is venous congestion, which may be associated with slight œdema. The author suggests that these irritative states produce an elevation of blood pressure by means of a continued series of sensory stimuli. These stimuli give rise to pressor effects. He also deals with synovitis of the vertebral joints, which he regards as by no means uncommon. The treatment which he has adopted for these conditions is exclusively mechanical, and is described as immobilization of the spinal column. He appends the histories of six cases, with the blood pressure records throughout the period of observation.

(32) The Treatment of Pellagra.

In dealing with the treatment of pellagra, A. H. Herold (*New Orleans Med. and Surg. Journ.*, October, 1917) refers to the injurious effects of injudicious arsenical treatment. Improvement at times follows the discontinuation of this medication. He records the results obtained in the treatment of five cases. Salvarsan proved of no value. In one case, troublesome symptoms, reminiscent of an acute attack, appeared for the first time after three years. There were in addition signs of postero-lateral sclerosis of the cord. The patient was going rapidly down hill. On the assumption that blood contains something that is lacking in pellagra, he determined to treat the patient by giving intravenous injections of normal horse serum. He could not determine whether this substance was vitamine or albumin. Three injections were given at two-day intervals. The symptoms improved, with the exception of those caused by the cord lesion. Eventually, however, the patient died. In the four following cases he gave injections of horse serum, chemically preserved, to which he added a lime salt, for the purpose of increasing the coagulability of the blood and also to obviate anaphylaxis. He claims that all four patients were cured and have remained well. He notes that two other patients were being treated in the same manner and were progressing well.

NEUROLOGY.

(33) Aphasia.

Marie and Foix (*Rev. Neurol*, Nos. 2 and 3, 1917) in an important paper based on examination of a great many cases of cranial injuries in wounded soldiers, came to the following conclusions regarding the localization of the speech functions: In the left cerebral hemisphere there were two distinct areas, one placed anteriorly, lesion of which produced anarthria; the other, placed posteriorly, lesion of which produced aphasia proper. Between the two was a mixed zone,

whose destruction determined global aphasia. The area producing anarthria corresponded superficially with the lower third of the ascending frontal convolution and small contiguous portions of the second and third frontal convolutions, beneath which lay the insula and the lenticular nucleus. It was impossible to determine whether the superficial or the deep lesion was the more fundamental. The third frontal convolution (as previously maintained by Marie) did not play an important rôle in the function of language. The anarthric syndromes were remarkable for their sudden onset and their favourable course. Several varieties could be distinguished. (*a*) There was anarthria, followed by complete or almost complete recovery in lesions placed anteriorly; (*b*) residual dysarthria, often attended by slight aphasia, when the lesion was placed posteriorly; (*c*) a slow, scanning speech, with sluggish ideation, when the lesion was high—a condition approaching that found after deep lesions in the anterior frontal region. Turning to aphasia, by which was meant aphasia proper, it was remarked that the prognosis was worse than in anarthria. The period of complete speechlessness was followed by a long period of aphasic trouble, coupled with general and decided intellectual dulling. The area or zone whose destruction produced aphasia was delimited approximately as follows: Above, by the intraparietal fissure; in front, by the central convolutions above the Sylvian fissure and below it by the line of meeting between the anterior and middle thirds of the temporal convolutions; behind, by the cuneus; and below, by the inferior margin of the hemisphere. There were distinct aphasic syndromes for the temporal, supramarginal and *pli courbe* regions, and minor syndromes for marginal lesions. The syndrome for the temporal region was the purest. Without noticeable anarthria, there was inability to name objects (loss of vocabulary), along with much impairment of speech comprehension, writing, reading and calculation. Intelligence also was reduced and hemianopsia was common. The syndrome of the supramarginal region was characterized by global aphasia, a combination of anarthria and aphasia, in which all the factors in speech were proportionately involved. Generally slight brachial monoplegia, motor and sensory, and sometimes bilateral apraxia was superadded. The syndrome of the region of the *pli courbe* and the posterior part of the first and second temporal convolutions was characterized by alexia, which was almost absolute. Writing, speech-comprehension, calculation and the naming of objects were affected, but not severely, and hemianopsia was constant. Anarthria was absent. The minor syndromes for marginal lesions varied with the relation of the lesion to the three regions mentioned. Deep-seated lesions between the anarthric and aphasic areas produced complete and lasting aphasia usually attended by hemiplegia and hemianæsthesia. It must be understood that this study dealt with lasting effects; it disregarded the transient, stuporose aphasia which might follow any head wound and likewise neuropathic mutism, and Marie maintained that it confirmed in a general way the views regarding aphasia adopted by him as the outcome of ordinary clinical and anatomical studies.

(34) Camptocormia.

Rosanoff-Saloff (*Nouv. Icon. de la Salpêtrière*, 1916-1917, No. 1) described a series of cases of acute flexion of the trunk in an anterior direction, occurring in soldiers who had either been blown up or buried by a shell, and rendered unconscious for a period of variable duration. The first symptom was lumbar pain, aggravated by movement, in consequence of which the patient immobilized his back and found greatest relative comfort in bending forward until the head was almost between the knees. This, in neuropathic subjects, as all such patients were, became a fixed attitude. The prognosis was good, provided cases could be treated early in a suitable hospital with proper medico-military discipline. It was recommended to put the patient in a plaster packet, with or without an anæsthetic, and fix him in a corrected position for eight, ten or fifteen days. In the writer's experience such treatment, coupled with proper discipline and a suitable environment succeeded without fail in effecting cure. Camptocormia, derived from the Greek words *κάμπτω*, I bend, and *κορμός*, the trunk, was a term suggested by Souques.

(35) Cerebro-Spinal Fever in the Royal Navy.

Rolleston (*Journ. Roy. Naval Med. Service*, 1917, *iii.*) reported that from August 1, 1915, to July 31, 1916, there were 104 cases of cerebro-spinal fever in the Royal Navy, as compared with 170 cases during the first year of the war. Of these 70 were below 20 years of age. Thirty-seven (35.6%) proved fatal, as contrasted with ninety (52.9%) during the first year of the war. Only those cases in which meningococci were found in the cerebro-spinal fluid were included, cases with meningeal symptoms and meningococci in the naso-pharynx only being ruled out. During the acute stage swabs from the naso-pharynx were often negative. The mode of onset sometimes varied from the common form characterized by fever, malaise, headache, and vomiting. Eight patients were discovered unconscious, 4 of these died. Four cases suggested pneumonia and one appendicitis. A rash was found in 51 cases, in 41 it was petechial or hæmorrhagic. A profuse hæmorrhagic rash was ominous, other rashes were not necessarily of grave significance. Herpes was noticed in 21 cases (labial in 20), photophobia in 10, conjunctival hæmorrhages in 5, strabismus in 8, ptosis in 3, and hemiplegia, facial paralysis, dysarthria and dysphagia, respectively, in one case. Mixed infections of the cerebro-spinal fluid were found in three cases. Of 95 cases treated intraspinally with some kind of serum, the mortality was 30 (31.6%). During the first year of the war, out of 105 cases, there was a mortality of 64 (61%), which seemed to justify the widely-expressed view that the earlier serums were deficient in antibodies. Vaccines were given in 8 cases without benefit. Serum rashes were observed in 23% of the cases and usually appeared on the tenth day after the first injection.

(36) Longitudinal Sinus Injections in Infants.

Brown and Smith (*Amer. Journ. of Dis. of Children*, June, 1917), in making intravenous injections and obtaining blood for therapeutic and diagnostic purposes in infants, advocated the use of the superior longitudinal sinus instead of other veins which are not always accessible. They based their recommendation on 52 successful infections of salvarsan, four of saline and two of diphtheritic antitoxin; and on forty-two cases in which blood had been taken, either for the Bordet-Wassermann test, or for cultural purposes. They advised entering the fontanelle at its hindmost part, because there the sinus was larger than more anteriorily. Untoward symptoms from transfixation of the sinus were not to be feared; this accident had happened to them on four occasions and in none had there been bad results. It was to be avoided by using a special needle with a guard placed 0.6 to 0.8 cm. from the point. The facility of the operation was illustrated by the case of a six-day-old infant which was taken from its cot sleeping and given 60 c.cm. of saline without being awakened.

(37) The Treatment of Syphilis of the Nervous System.

Swift (*Amer. Journ. of Syphilis*, July, 1917) pointed out that before undertaking the treatment of any case of cerebro-spinal syphilis it was important to ascertain what symptoms were due to inflammation or exudation, and what to degeneration of tracts or cortex. Most cases of early meningitis and of what was formerly called tertiary syphilis of the nervous system responded to the general administration of salvarsan, mercury and potassium iodide; so did some cases of *tabes dorsalis*, but in others and in general paresis the addition of intraspinal injections of blood serum taken from the previously salvarsanized patient was advisable. Treatment, whatever the kind and whatever the case, should not be suspended until the cerebro-spinal fluid was normal. Concerning general paresis, while such treatment might afford relief by increasing the number and length of remissions, the ultimate hope for recovery was slight. As a premonitory indication of general paresis, an alteration of the "gold curve" in the cerebro-spinal fluid (Lange's test) was to be watched for, and when found was to be taken as justification for intensive treatment.

No. 4 AUSTRALIAN GENERAL HOSPITAL.

Early in 1915 the Minister for Defence called into being an Advisory Committee for Military Hospitals and Convalescent Homes in New South Wales. The members of this Committee were nominated by various public bodies, including the Municipality of Sydney, the Red Cross Society, and the Chamber of Commerce. The Lord Mayor of Sydney was appointed Chairman, but neither he nor any of the nine other members possessed any expert knowledge in hospital administration. We understand that the Committee met on a few occasions in 1916, but have failed to ascertain the nature of any recommendations of moment to which effect has been given.

In 1917 the Minister for Defence instructed the Committee to enquire into the administration of the No. 4 Australian General Hospital at Randwick. We have had occasion, from time to time, to refer to the want of disciplinary control exercised over patients at this Hospital. In our issue of August 14, 1915, we urged our readers to take a large view of the position of the military hospitals then in course of construction, and to consider future developments before indulging in general condemnation of the then existing arrangements. We stated that the soldiers at the No. 4 Australian General Hospital were housed under incomparably better, more hygienic and more congenial conditions than were their predecessors, the unfortunate little ones, whose crime was misfortune. We arrived at the conclusion that the Hospital promised to be an excellent, up-to-date Hospital, suitably adapted to the needs of war time, and made the suggestion that, at a later date, we would record whether these promises had been fulfilled.

It is obvious that the reference to the Hospital Advisory Committee concerning the No. 4 Australian General Hospital originated, in part, in the many adverse criticisms which were current in Sydney and elsewhere, especially during the second half of 1917. It appears, however, from the Report that the Principal Medical Officer of the No. 2 Military District and the Officer Commanding the Hospital were not working harmoniously, and we suspect that the enquiry was precipitated as a result of some complaint lodged by the Principal Medical Officer concerning his subordinate Medical Officer. It is significant that the Committee had its first meeting in October, 1917, while at the end of September, 1917, a notice appeared in the District Orders constituting a Court of Enquiry, without any mention being made of the circumstances into which this military tribunal was to enquire.

The Committee sat at intervals, until the middle of November. Eventually, two reports were submitted to the Minister. The first report was signed by R. D. Meagher, R. W. Richards, J. H. Catts, W. G. Layton, and D. F. Dwyer; while the second was signed by Enid Macarthur Onslow, Edith A. Hill, Charles W. Oakes, H. Lamond and George A. Parkes. The Chairman of the Committee converted the former into a majority report by adding his second vote as Chairman. On January 7, 1918, the conclusions arrived at by the five members led by the Chairman and those arrived by the other five members of the Committee, together with what purported to be a summary of the evidence, appeared in the daily press. We made an application for a copy of the complete report, together with the evidence. It appears, however, that the documents supplied to the daily press represented everything that had been submitted by the Committee to the Defence Department.

The following are the conclusions, as published in the daily press of the Meagher report:—

(1) That the hospital is as well conducted, and its offices as efficiently administered, as the circumstances attending and consequences following the attempt to adapt an old building originally constructed, devoid of modern principles, together with administrative circumlocution, will permit.

(2) The Officer Commanding should be consulted in regard to all work and repairs in connexion with the hospital.

(3) The Officer Commanding should be provided with £100 in the suspense account to cover urgent minor requirements to be reimbursed from time to time.

(4) That greater service could be rendered if there was a better type of orderly selected other than a youth anxious to go to the front, who regards his time and duties at Randwick Hospital as of a perfunctory character; and that there should be more fixity of tenure in such positions, and they should be given, where possible, to returned soldiers.

(5) That the recommendation to appoint an officer like Captain Lewis to take control of the business side of the hospital, under the Officer Commanding, thus leaving more time for concentration in the essential hospital administration work by the Officer Commanding, is an excellent suggestion, in view of the splendid work done by Captain Lewis in a similar capacity at Gladesville Asylum, and should be adopted.

(6) That the circumlocution process in operation regarding urgent matters of material, repairs or commodities, in the method of sending to Melbourne for ratification, should be obviated, such as neglect to comply with a requisition for an ice-house for several months, by which meat went bad, and Quartermaster Ward's requisition for insulated dinner tins (to give patients food in a hot state) being turned down by headquarters.

(7) That the officers of the guard should be men appointed on the recommendation of the Officer Commanding, and responsible to him directly for the proper discharge of their duties, the same as any member of the hospital staff. The committee believe by this means the transport of alcohol to the hospital and the worry to the nurses and doctors would be minimized to vanishing point.

(8) The Principal Medical Officer should have greater facilities provided for the reception at suitable places of convalescents from No. 4 Military General Hospital.

(9) The apparent studied attempt of the Principal Medical Officer to ignore the Officer Commanding by visiting the institution and not seeing him and taking a junior officer through the establishment, is calculated to have a detrimental effect on the institution, and the concomitant conditions in which the Staff Officer for Works and his officers ignore the Officer Commanding in any works, either excavations in the grounds or constructions. The statement of Mrs. Macarthur Onslow:—"It is very degrading that the Officer Commanding such institution should be in such a position"—is fully endorsed by the committee.

(10) As No. 4 is the main military hospital in New South Wales, your committee proposes to meet there monthly in order to keep closely in touch with its general administration.

(11) It is worthy of note that out of 13,000 patients, 6,000 treated since January last, not one gave evidence in any way reflecting on the skill and administration of the hospital.

(12) With adjustments and reforms made as indicated and with fuller powers given to the Officer Commanding, and with more harmonious co-ordination of relationship by the Principal Medical Officer towards the Officer Commanding, there is no reason to apprehend that the military hospital (No. 4) will not give the fullest satisfactory results.

The following are the findings of the remainder of the Committee:—

(1) That the administration of No. 4 General Hospital is not up to the standard that the general public have a right to expect in a first-class military hospital.

(2) That the Officer Commanding No. 4 General Hospital does not exercise that constant supervision and control that are essential to the successful management of the institution. This officer does not appear to be able to maintain discipline, or to fully grasp the responsibilities of his position as commanding officer.

(3) The Registrar does not devote sufficient time to the work of the hospital to enable him to efficiently carry out his duties.

(4) The cleanliness of the hospital is not efficiently maintained, but to what extent this is due to want of supervision on the part of the Matron is not easily determinable. From the evidence placed before the committee, it would appear that the Matron is required to undertake more duties than she can effectively perform, and she is without that support that an efficient commanding officer would accord.

(5) The Secretary—we find that the Secretary's department is most efficiently conducted.

(6) The Quartermaster's work is well done in certain particulars, but he does not appear to have sufficient control of the staff.

(7) The original buildings when first taken over for the purpose of a general hospital were unsuited to the requirements, but the expenditure of over £80,000 for improvements have afforded facilities which admit of greater efficiency than obtains under the present management.

(8) The limits of the inquiry make it impossible to express a considered judgement upon the efficiency of the Principal Medical Officer, whose duties extend to all the military hospitals in the State, but the reason given by the Principal Medical Officer for his failure for more than a year to take steps to secure more efficient command of the hospital—the Commanding Officer had been appointed in preference to an officer recommended by him—does not appear to the Committee a sufficient reason for this long delay in dealing effectively with the position.

(9) The inquiry was not followed into all the details of the hospital management, the Committee being satisfied that more efficient control will lead to immediate reorganization and consequently to greater efficiency at this hospital.

(10) From the information placed before the inquiry the Committee is of the opinion that more co-ordination should exist between the hospital authorities and the Works Department.

In the former report it is recorded that the Committee sat on eleven occasions, and examined 15 witnesses. The evidence of some of the witnesses is quoted in support of the contention that the buildings of the Hospital were not adapted to their present purpose. Colonel E. S. Stokes stated that when he entered upon his duties as Principal Medical Officer on December 1, 1915, he found that things were very chaotic. He had to evolve order out of this chaotic state of affairs. He had no fixed time for visiting Randwick. He had not reported concerning the unsatisfactory condition of affairs to the State Commandant, as he regarded it to be his duty to attempt to remedy the defects. After six months there was a great improvement. He expressed the opinion that the No. 4 Australian General Hospital was a first class hospital, if allowance were made for its birth and development. He stated that if the Officer Commanding had wished anything to be done, it would have been the most natural thing for him to have referred the matter to him (witness). Witness stated that he had no strained personal relations with the Officer Commanding. He thought that this officer's views of him would lead him (witness) to believe that relations were strained.

The evidence of the Officer Commanding No. 4 Australian General Hospital, Lieutenant-Colonel George Lane Mullins, is condensed in the published report into the following sentence: He did not regard the site as an ideal spot for a military hospital, but he had absolutely nothing to do with its selection, nor advising the military authorities, the same having been determined on before he took office.

It appears that Colonel George Cuscaden, Principal Medical Officer of No. 3 Military District, had been requested by the Committee to inspect the Hospital, and to give evidence concerning its administration. In the first report the five signatories express their strong disagreement with a condemnatory report by "Colonel G. Cuscaden, Principal Medical Officer of Victoria" (*sic*) "concerning, among other matters, the qualifications and physical and mental condition of the commanding officer of the hospital." Colonel Cuscaden was not satisfied with the medical and surgical wards. They did not seem to be properly kept. "After visiting the wards and having heard the evidence of eminent surgeons and physicians, the Committee could not but regard the remarks of Colonel Cuscaden as gross exaggeration. His report on the Hospital, he stated, was unfavourable. The present staff, in his opinion, was not sufficient. In the conclusion of his report, he expressed the opinion that the commanding officer was both mentally and physically defective. The Colonel set forth his qualifications for giving the opinion he had expressed. His experience was somewhat limited and confined and, recognizing the professional qualifications and experience of the commanding officer, it is fair to assume that Colonel Cuscaden was junior in every respect than years to the Officer Commanding, whose qualifications might be rated as among the highest in the profession. Colonel Cuscaden had not had military experience at the front. His report was generally condemnatory in specific terms of the commanding officer, but having regard to the manner in which the commanding officer gave his evidence, and his knowledge of the details of administration of the Hospital, and his alertness in combating hostile questions, Colonel Cuscaden's opinions were not justified. In fact, as Dr. Sir Herbert Maitland had put it, 'the commanding officer was particularly mentally alert. Although stout, he was staunch physically,' a view that must be acceptable to those present during a long, searching examination of Colonel Lane Mullins." The remainder of the first report appears to be taken up with a summary of the evidence of Lieutenant-Colonel Sir Herbert Maitland. This witness did not regard the sanitary arrangements as perfect, and stated that the ventilation was not as it should be. The building was obsolete. He had no reason to doubt the capability for his position of the Officer Commanding. He thought that the Hospital was as clean as any civil hospital, and that, considering the difficulties, the public was getting as good results as could reasonably be expected, "for the place was totally unfit." He was astounded to hear that £80,000 had been spent on the Hospital.

From the various versions published in the daily press, we are unable to find any reference to the body of the so-called minority report.

THE CARE OF CHILDREN BY THE STATE.
NEW SOUTH WALES.

The annual report of the President of the State Children Relief Board, Mr. Alfred William Green, for the year ending April 5, 1916, is a document replete with important data and carefully considered opinions. The activity of the Department and the policy which it has steadfastly followed during the past few years, have secured for it the first place among the State Children Boards of Australia and one of the first places in the world.

There has been a considerable expansion of the work undertaken and, concurrently, a considerable increase in the amount spent on this work. The report justifies the expenditure. In the first place, it was resolved to increase the amount of relief granted to children of widows and deserted wives. In the second place, the system of boarding out State children has been developed. In connexion with the policy of favouring a boarding-out system, as opposed to the institutional control of children, Mr. Green deals in considerable detail with the allegations of ill-treatment and neglect which have been levelled against the Board. In every case where ill-treatment or neglect has been alleged, full enquiries have been made and, as a result, it has been found that the charges were quite baseless in the majority. Ill-treatment was discovered in some instances in connexion with children who were not wards of the Board. He claims that any abuse of the boarding-out system is readily detectable on account of the system of inspection instituted, and because the public is very ready to criticize and to expose flaws in any State system. The school teacher, the clergy, the police and the neighbours supplement the investigations of the salaried inspectors and local visitors, and therefore it would be inconceivable that any cruelty to State children should remain undiscovered. As an appendix to the report, he publishes replies from the teachers in 1,135

State schools to enquiries on this subject. In 1,030 cases the replies were entirely satisfactory. There were 105 cases of various alleged defects which, when investigated, were reduced to 34. Of the 34, 23 were shown to be "minor items of complaint." The alleged defects included complaints that the children lived a long distance from school, that they were children of blood relatives, and that the school attendance was above the legal requirements. In a few cases the complaint was made that a large number of children were boarded in one home. On investigation, it was found that six children were boarded out in one home, and in two others there were five children. The homes in all three cases were found to be exceptionally good. It is stated that the enquiries have benefited the system, and have disclosed a need for further legislation relative to the supervision of the children placed out from private establishments or by relatives. Means for controlling advertisements relating to the adoption or private boarding out of infants are also needed. A typical case illustrating the harm that can be done under the present legislation, is cited.

Under the *State Children Relief Act* children are boarded out with strangers or relatives until they are fourteen years of age. The payments made for the maintenance of these children are as follows: 12s. per week for young ailing infants; 10s. per week for children under one year; 8s. per week up to two years; 7s. per week up to three years; 6s. per week up to ten years, and 5s. per week up to fourteen years. These payments are less than those made in the other States for children between three and fourteen years of age. In South Australia, 6s. per week is paid for girls between two and thirteen years of age, and the same amount is paid for children of both sexes in Victoria. In all other instances 7s. per week is paid.

The total number of children placed out under the State Children Relief Act was 12,391. Of these, 7,310 were boarded with their mothers. The proportion of State children to the population was 6.6 per 1,000. The proportion of children boarded with their own mothers was 3.9 per 1,000. Mr. Green attempts to show that the cost to the State would be very materially greater, were the children placed in orphanages and industrial schools instead of being boarded out. The maintenance in these institutions in the several States varies between 5s. 10d. and 10s.

The total expenditure of the Department during the year was £156,631, which represents £22,185 more than that spent in 1915. Nearly £60,000 was spent for the maintenance of children boarded out apart from their parents. Deducting the contributions by parents and the repayments of maintenance charges, the actual cost to the State of each child was £17 0s. 11d. The State expended £10 10s. 8d. on each child boarded out with its mother. The amount collected from parents and relatives toward the support of these children amounted to £3,736. It is regarded as unlikely that these contributions will be increased to a material extent under the present conditions.

In addition to the children boarded out, there were 1,268 children registered under the Children's Protection Act, 500 in licensed institutions, 695 engaged in street trading, 1,566 released on probation and 180 employed in theatres. The total number under inspection was therefore 16,600. Inspection is carried out by 33 salaried officers of the Board, but during the course of the year some of these officers have been absent on military duty, some have been absent on sick leave, and some have retired. It is suggested that 40 officers are required to carry out the work efficiently. The work of the salaried officers is supplemented by that of honorary officers. These are lady visitors who work in the districts in which they live, and visit the children belonging to their own religious denomination.

The duties of the salaried inspector are very wide. They cover the enquiries connected with the applications for admission and discharge of children, the inspection of State children under various conditions, including lying-in homes and nursing homes, investigations into the home surroundings, the work entailed in prosecutions, enquiries into cases of neglect, ill-treatment, truancy, school exemption, street training, theatre licences and the like, enquiries into affiliation orders and maintenance cases, the collection of maintenance and other matters. During the year, 29,809 visits were paid to 5,361 homes. In addition, 6,321 visits were paid to homes in which the children were under supervision in accordance with the provisions of the *Children's Protection Act*, 6,460 visits were paid to children on probation, in addition to approximately 12,000 visits paid to them by honorary officers and 15,635 visits were paid in connexion with the supervision of school attendance. The total number of investigations was 72,679.

Under the *Neglected Children and Juvenile Offenders' Act* the officers have power to obtain regular attendance at school. There were only 232 prosecutions under the compulsory clauses of the *Public Instruction Act*, although 817 cases of general neglect were dealt with in the Children's Court. School attendance in these instances is the subject of special direction by the magistrate, and any further neglect renders the children liable to committal to institutions for breach of the conditions of their relief on probation.

Of the 5,081 children provided for apart from their mothers, 3,651 were entirely supported by the Government, 1,025 were apprenticed and 281 were adopted without payment. The new admissions totalled 1,459, while the number of those discharged to relatives or friends was 749, to various homes, institutions, etc., was 72 and to guardians 79. Eight lads enlisted, four went to sea, 36 absconded, 289 were discharged on account of being over age and 34 died. Of the children admitted during the year, 499 came from Children's Courts, 57 from the Benevolent Asylum, 12 from private institutions, 81 from public institutions and 24 from the police, and 781 were boarded out direct.

In dealing with these children, the Board does not usually commit more than three children to any one guardian. Exceptions are made in the case of brothers and sisters. All the homes to which children were sent, are kept under constant supervision. At the close of the financial year the 4,530 children out apart from their parents were distributed among 2,816 homes as boarders, as apprentices or under adoption. The first class represents 50.9%; the second 46.8% and the third 2.3%. Excellent results have been obtained on the Hawkesbury River, where 139 State children were placed out with 73 guardians. Of these children, 65 were lads committed from the Children's Court as juvenile offenders or neglected or uncontrollable children. Truancy becomes impossible because a launch is sent to take them to and from school. The apprenticed children are occupied either on farms or as domestic servants. Approximately, 66% of them are situated in country districts. Mr. Green points out that the existing scale of payments to apprentices still needs revision and, further, that it is necessary to provide for their preliminary training prior to apprenticeship.

The adopted children remain under State supervision and protection. In the majority of cases they were found to have an excellent home and to be treated as members of the family.

At Mittagong there are three Homes for invalid and delicate children. These children include deformed boys and girls for whom special training is necessary on account of their deformity. The girls learn housekeeping, cookery, laundry work and dressmaking, and the boys poultry raising, gardening, tailoring, bootmaking and carpentry. At Parramatta there are two Cottage Homes for delicate children and one for feeble-minded girls. Further provision for feeble-minded children exists at Mittagong and at Raymond Terrace. The inmates of the two Homes at Mittagong are under the care of an excellent Matron and her daughter and of an expert visiting teacher, who attends the school. The results obtained are excellent, partly because only a small number of children are dealt with at the one school, so that individual tuition becomes possible, and partly because those in charge have made their work a labour of love. It is the intention of the Board to establish a labour colony for these children as they pass out of the school. The Home at Parramatta is administered in a similar manner, and the general progress of the children is said to have been satisfactory. The Board endeavours to secure these children at as early an age as possible. It has been found that less can be done for children over ten years of age than for the little ones. Epileptics are not retained in these schools. At Raymond Terrace 33 boys were admitted during the year and 31 were discharged. In three cases situations were found for the children; in 14 they were transferred to situations with farmers, and in four they were returned to their relatives, being over age. One boy enlisted, four went to sea, one was transferred to a hospital for the insane and four were boarded out.

A considerable amount of interesting information is given concerning the work of the boys at the Farm. Lack of space renders it, however, impossible to deal with this subject here.

There are three homes where mothers can be admitted with their babies. During the year, 42 mothers and 52 babies were cared for in the Eastwood Home. Of these, 27 mothers and 38 babies were discharged, two babies died and, at the end of the year, 11 mothers and 13 babies were still in the institution. Three expectant mothers were also looked after. The average period of care was five months. In the Cicada Home 51 mothers and 69 infants were under care. During the course of the year 42 mothers and 46 infants were discharged, three babies died, and 19 mothers and 23 infants remained in the Home at the end of the 12 months. The average period of care of the infants was four months. The Hillside Home, Paddington, is an institution which has replaced a private home for ailing infants. The number of admissions of mothers during the year was 29, and of infants 93, and, in addition, 20 expectant mothers were received. Only one infant died, while 36 mothers, 17 expectant mothers and 98 babies were discharged. The number of mothers and babies in the Institution at the beginning of the year was 12 and 10 respectively, and at the end of the year five and five. Mr. Green speaks very highly of the value of the work accomplished in these Homes, more especially in providing mothers with means for improving the state of their health before the lying-in period, and of giving them proper instruction concerning the rearing of infants after the birth. The necessity for special care in the case of illegitimate infants is shown by a comparison of the infantile mortality out of wedlock with that in wedlock. In 1915 the legitimate death-rate was 64.24 and the illegitimate infantile death-rate was 140.99.

The last institution dealt with under this section of the report is the "Ormond House" Central Depôt for State Children. It appears that no less than 1,825 children passed through this home during the course of the year. These children had been dealt with in the various children's courts.

In the second division of the report the children boarded out with their own mothers are dealt with. At the end of the year, 2,545 widows and deserted wives were in receipt of allowances for the support of their own children. The total number of children in this category was 7,310. There were applications received from 1,492 mothers during the year. The assistance was granted in 955 cases and refused in 537. In the great majority of cases 5s. a week was paid for the child; in a large number 4s. was paid, while 3s., 2s. 6d., 3s. 6d., 2s. and 4s. were paid in this order of frequency. Ten shillings and 8s. were paid for one child each, 7s. 6d. in the case of two children, 7s. in the case of one child and 6s. in the case of three children. In a few instances 4s. 4d., 3s. 9d. and 3s. 4d. were paid. Of the 2,545 mothers, 1,443 were widows and 1,102 deserted wives. There were 523 mothers whose husbands had deserted them, and 579 whose husbands were insane, in gaol, in asylums or in hospitals.

The third division of the report deals with the *Infant Protection Act* of 1904. This Act provides for the supervision, maintenance and care of children up to the age of 7 years, either in private homes or in religious establishments. The children are kept apart from their parents. There is a number of institutions and religious establishments for the reception of these children. The largest of these is the Foundling Home at Waitara, where 79 children were taken care of during the year. There were 48 children at the Infants' Home at Ashfield, 43 at the Norland Nursery, Waverley, 33 at the St. Michael's Orphanage, Baulkham Hills, 31 at the Dalmar Children's Home, Croydon, and 30 at the Burnside Presbyterian Homes at Parramatta, in addition to numbers ranging from 6 to 18 in other homes. In the aggregate, 389 children were dealt with in this way. The number of admissions to the Waitara Foundling Home during the year was 65, 42 being with their mothers and 23 without. The total number of deaths during the year at this Institution appears to be 25. There were 33 children admitted with their mothers to the Ashfield Infants' Home and 32 without. The deaths numbered five. The causes of death given include gastro-enteritis, morbilli and syphilis. In addition to the Institutions, 81 private homes were licensed to receive infants up to the maximum number of five. Eight applications were refused, or the licences withdrawn, because of the unsatisfactory character of the applicants or of their homes. In this connexion, improved regulations under the Act have been submitted to the Minister for approval. The regulations have been drawn up with a view to the removal of some of the defects obtaining under the old conditions.

The Metropolitan Children's Court deals with children who are neglected, uncontrollable or delinquent, with children under 14 years of age whose mothers, being widows or deserted wives, apply for monetary relief, with cases affecting children and adults in association and with affiliation cases under the *Infant Protection Act*. During the course of the year, 1,948 children were brought before the Court. Seven boys were fined for minor offences, such as stone-throwing. The number of children committed to the farm homes, industrial school and training home, was 265, while 1,051 were released on probation and 82 were committed to the care of persons. The remaining 110 were committed to the care of the State Children's Relief Department and to the rescue homes.

At the Metropolitan Boys' Shelter, 1,207 boys were placed under control. Dr. Colin Stewart, a member of the medical staff of the Department of Public Instruction, visited the Shelter three times a week and, during the course of the year, examined 562 boys. "Before being seen by the doctor, the boys were tested by the Binet-Simon method as to their mental capacity." We understand that before the Department of Public Instruction claimed this field of medical activity as its own, the work of testing the mental capacity of these children was carried out by Dr. Andrew Davidson, whose experience in psychiatry proved invaluable to the children. We regret that this work is no longer being conducted by a medical practitioner. The mentality of the children was said to be below normal in 204, normal in 356 and above normal in 2. The physical defects discovered included 61 of the throat, 71 of the nose, 12 of the ear and 43 of the eye. In 84 instances circumcision was performed. There were 1,566 children released on probation. The ages of these children were as follows: between 5 and 10, 211; between 10 and 12, 351; between 12 and 14, 537; between 14 and 16, 467. In regard to the offences committed the following information is contained in a table. Under the heading "neglected" there were 184 children, under "uncontrollable" there were 329, under "stealing" there were 719, under "minor offences" there were 230, under "serious offences" there were 104. The behaviour of 1,146 children on probation was excellent; that of 204 was satisfactory and that of 216 was unsatisfactory.

During the course of the year, 695 boys were licensed for street trading, hawking newspapers, flowers and other articles. Juvenile pavement "artists" have been practically eliminated through the activity of the Board, and licences are only given when it is held that their issue will not result in injury to the children's moral welfare. The Department discourages the adoption of street trading as a permanent means of livelihood. Each licensed child wears a badge, and particular attention is paid to the school attendance of these children.

There were 205 applications for theatre licences of children, and of these 25 were refused. Mr. Green calls attention to a defect in the Act which precludes the Department from interfering in the case of a child being exhibited.

Under the *Children's Protection Act* the State has control over infants up to three years of age placed out for payment apart from their parents, and over the houses into which more than one infant is received. Under this Act, 8,064 lying-in homes were registered, in addition to 126 foster homes and 1,268 children. Of these children, 523 were placed in hospitals and asylums. There were 52 deaths, 38 of which were caused by gastro-enteritis.

The report contains a considerable amount of further information of importance, to which, however, it is impossible to refer at present.

Dr. A. H. Tebbutt has recently returned from France, and is resuming his duties as Chief Resident Pathologist at the Royal Prince Alfred Hospital. While on active service he commanded the 14th Field Ambulance, holding the rank of Lieutenant-Colonel. He is now residing at The Albany, 201 Macquarie Street, Sydney.

The following have been elected members of the New South Wales Branch of the British Medical Association:—

Elma Linton Sandford, M.B., Ch.M., 1917, Univ. Sydney, Royal Alexandra Hospital for Children, Camperdown.

Charles Aloysius Burfitt, M.B., Ch.M., 1916, Univ. Sydney, 222 Glebe Road, Glebe Point.

Correspondence.

THE MENACE OF THE BIRTH-RATE.

Sir,—While we as a profession are condemning the limitation of births and looking for means to remedy such limitation, are we not amongst the chief offenders? How many medical men in Australia have families of more than four children in each? It would be interesting to know.

I have two sons and two daughters who are all married (I married at 22). I considered four children were as many as I could afford to provide for, and if I could do so I think many others could afford larger families. But what is the case?

Yours, etc.,

14th January, 1918. PATER FAMILIAS.

PRESERVATIVE FOR COCAINE AND OTHER ALKALOIDS.

Sir,—I have no doubt that Harman's diluting fluid, as recommended by Dr. Graham Brown, is a good preservative. I should like, however, to bring under notice another, first recommended, I think, by that accomplished ophthalmologist, the late T. K. Hamilton, of Adelaide, and that is, chloretone. A half per cent. solution of chloretone has the advantage of being simple, easy to prepare, colourless, odourless, cheap, can be used for instillation or subcutaneous injection, and preserves cocaine, homatropine, or any alkaloid used in ophthalmic work, even the notoriously unstable salts of eserine and pilocarpine for an indefinite period.

Yours, etc.,

F. ANTILL POCKLEY.

227 Macquarie Street, Sydney,
21st January, 1918.

Proceedings of the Australian Medical Boards.

NEW SOUTH WALES.

The following additional registrations have been made:—

Halloran, Garnet Reginald, M.D., 1917, Univ., Sydney.

Tunks, Ormond Gillespie, Mast. Surg., 1917, Univ. Sydney.

QUEENSLAND.

The undermentioned has been registered, under the provisions of "The Medical Act of 1867," as a duly qualified medical practitioner:—

Shield, Carrie, Brisbane Hospital, M.B., Ch.B., Univ. Melb., 1917.

Medical Appointments.

IMPORTANT NOTICE.

Medical practitioners are requested not to apply for any appointment referred to in the following table, without having first communicated with the Honorary Secretary of the Branch named in the first column, or with the Medical Secretary of the British Medical Association, 429 Strand, London, W.C.

Branch.	APPOINTMENTS.
VICTORIA. (Hon. Sec., Medical Society Hall, East Melbourne.)	All Friendly Society Lodges, Institutes, Medical Dispensaries and other contract practice. **Australian Prudential Association Proprietary, Limited.** **National Provident Association.** **Life Insurance Company of Australia, Limited.** **Mutual National Provident Club.**
QUEENSLAND. (Hon. Sec., B.M.A. Building, Adelaide Street, Brisbane.)	**Medical Officers to the Selwyn Hospital, North Queensland.** **Brisbane United Friendly Society Institute.**
SOUTH AUSTRALIA. (Hon. Sec., 3 North Terrace, Adelaide.)	**The F.S. Medical Assoc., Incorp., Adelaide.** Contract Practice, Appointments at Renmark.
WESTERN AUSTRALIA. (Hon. Sec., Health Department, Perth.)	**All Contract Practice Appointments in Western Australia.**
NEW SOUTH WALES. (Hon. Sec., 30-34 Elizabeth Street, Sydney.)	Australian Natives' Association. Balmain United F.S. Dispensary. Canterbury United F.S. Dispensary. Leichhardt and Petersham Dispensary. M.U. Oddfellows' Med. Inst., Elizabeth Street, Sydney. Marrickville United F.S. Dispensary. N.S.W. Ambulance and Transport Brigade. North Sydney United F.S. People's Prudential Benefit Society. Phœnix Mutual Provident Society. F.S. Lodges at Casino. F.S. Lodges at Lithgow. F.S. Lodges at Parramatta, Penrith, Auburn and Lidcombe. Newcastle Collieries — Killingworth, Seaham Nos. 1 and 2, West Wallsend.
TASMANIA. (Hon. Sec., Belrive, Tasmania.)	Medical Officers in all State-aided Hospitals in Tasmania.
NEW ZEALAND: WELLINGTON DIVISION. (Hon. Sec., Wellington.)	Friendly Society Lodges, Wellington, N.Z.

Diary for the Month.

Jan. 29.—N.S.W. Branch, B.M.A., Council.
Jan. 30.—Vic. Branch, B.M.A., Council.
Feb. 1.—Q. Branch, B.M.A., Meeting.
Feb. 6.—Federal Committee of the B.M.A. in Australia, at Melbourne.
Feb. 6.—Vic. Branch, B.M.A., Monthly Meeting; Presentation of Balance Sheet for 1917.
Feb. 12.—Tas. Branch, B.M.A., Council and Branch.
Feb. 12.—N.S.W. Branch, B.M.A., Ethics Committee.
Feb. 14.—Vic. Branch, B.M.A., Council.
Feb. 19.—N.S.W. Branch, B.M.A., Executive and Finance Committee.

EDITORIAL NOTICES.

Manuscripts forwarded to the office of this Journal cannot under any circumstances be returned.

Original articles forwarded for publication are understood to be offered to *The Medical Journal of Australia* alone, unless the contrary be stated.

All communications should be addressed to "The Editor," *The Medical Journal of Australia*, B.M.A. Building, 30-34 Elizabeth Street, Sydney, New South Wales.